8-9-10 June 2004 • Falls Church, VA• Sky 5, Suite 407 Conference Room A

"MTF Revenue Cycle Management"

Strengthening The Back End Processes

Cost Recovery Program
Core Competencies
MAC – MSA - TPC

UBO Pilot Training 8 - 10 June 2004

MTF Revenue Cycle Management ... Strengthening the Back End Processes

Opening Remarks & MTF Revenue Cycle 2004 (Mr. Tom Sadauskas, Deputy UBO Program Manager)

High level overview of Revenue Cycle Management, UBO Authority & Guidance, UBO purpose, mission and goal, organizational chart, Systems deployment update and future enhancements.

Third Party Collections (TPC) (Ms. Dawn Canales)

Overview of Third Party Collection Program (TPCP) fundamentals from policy/guidance through the business processes supported by the MTF Revenue Cycle. Topics include insurance identification/validation, file maintenance, reimbursement rates, claim submission, follow-up, posting collections and reporting. Discussion on the GAO, Patient Access DD2570, SIT/OHI file maintenance, current use of the SIT, and future features.

Claim Generation: MTF Professional & Institutional Charges (Lt Col JoAnn Kelsch)

This session will use the MTF revenue cycle to demonstrate how professional and institutional charges are generated and calculated for ambulatory and inpatient claims. This session is geared towards the new and experience biller who is responsible for responding to insurance company inquiries and educating MTF staff, Commanders and Service/Third Party auditors regarding what the charges on your MTF's submitted claims represent.

Processing Denied Claims (Ms. JoEllen Brophy)

Billable Events personnel will learn to identify what is missing or incorrect on a claim before it leaves the billing office. Learn how the front end processes have direct impact on the back end work flow. Establish processes to send a compliant clean claim out the door.

Medical Services Accounts (MSA) (Ms. Dawn Canales)

Overview of the Medical Services Accounts (MSA) program fundamentals from policy/guidance through the business processes supported by the MTF Revenue Cycle. Topics include internal controls, rates and patient categories, billing forms, billing process, collecting, depositing and reporting functions.

Medical Affirmative Claims (MAC) (Ms.JoEllen Brophy)

Overview of Medical Affirmative Claims (MAC) program fundamentals from policy/guidance through the business processes supported by the MTF Revenue Cycle. Topics include injury/claim identification, claim generation/ submission and support to and partnering with the base legal office.

Billing Work-Arounds (Ms Dawn Canales)

Discuss billing challenges and identified viable work-arounds for APV, Ancillary and Pharmacy billing. Answer questions like "How does pharmacy get billed in MSA?'

Strengthening the Back End Processes (Ms. Connie Briddell)

REPORTS: How, What, Why, When and Compliancy, Audits, Checklists, Desk Level Reference Tools

References and Resources

Glossary of Terms

Uniform Business Office (UBO) Pilot Training Course
UBO Overview

Tom Sadauskas

TMA UBO Deputy Program Manager

8 June 2004

Uniform Business Office (UBO) Overview

- UBO Mission
  - Purpose, Authority & Guidance
  - UBO Organization/Structure
- UBO Program Management
  - MTF Cost Recovery Programs
    - Itemized Billing
    - MTF Revenue Cycle Management
  - HIPAA and Electronic Billing
  - Resources

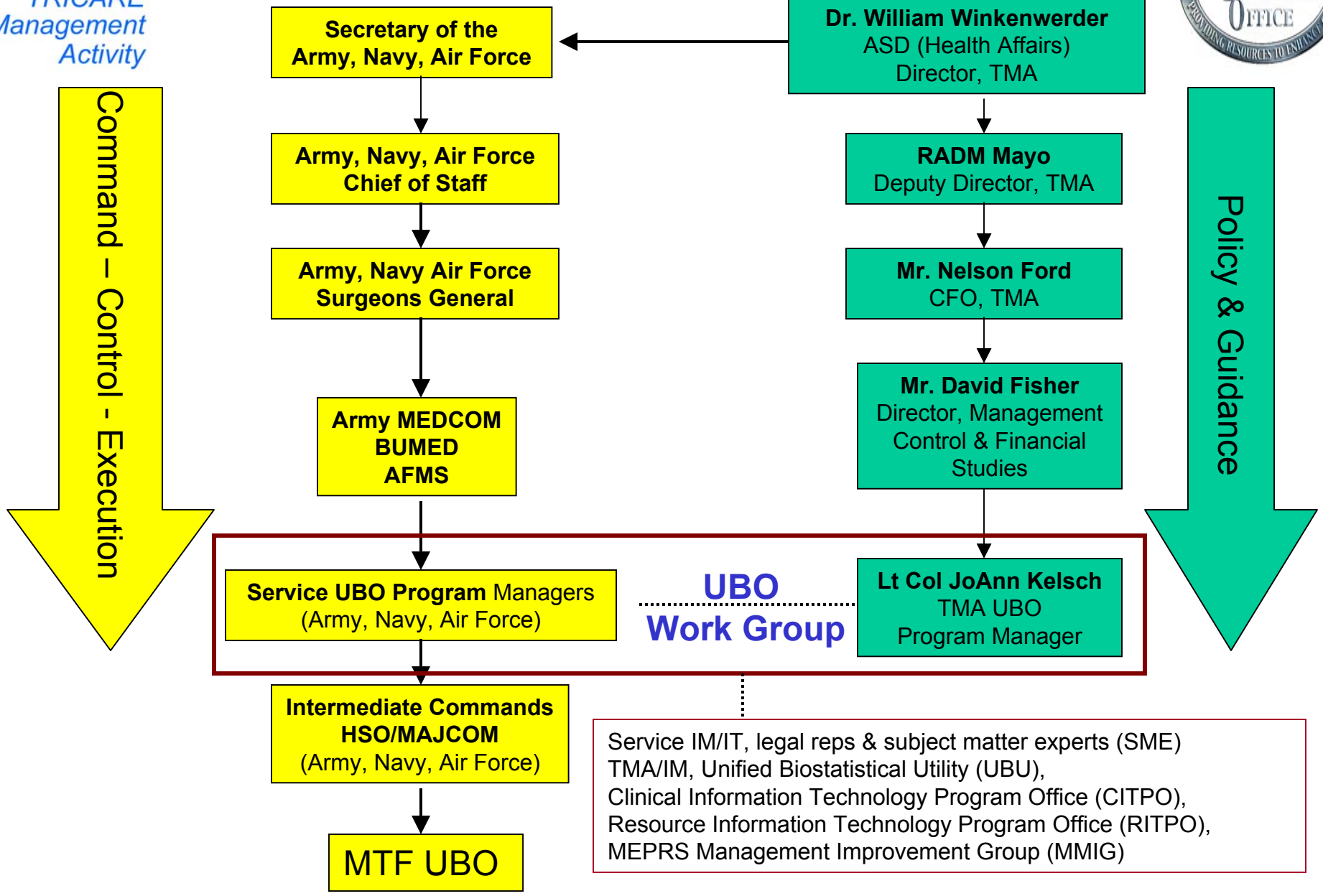
UBO Purpose & Mission

- **Purpose**
  - To consolidate collection processing, analysis, and reporting of accounting-related activities under one umbrella
    - Three programs within the UBO:
      - Third Party Collections (TPC)
      - Medical Services Account (MSA)
      - Medical Affirmative Claims (MAC)
- **Mission**
  - To optimize allowable health care cost recovery within compliance guidelines in order to support the operational and readiness mission of the MHS

UBO Authority & Guidance

- **Authority**
  - 10 U.S.C. 1095, Health care services incurred on behalf of covered beneficiaries
  - 32 CFR Part 220, Collection from Third Party Payers of Reasonable Charges for Health Care Services
  - 10 U.S.C. 1072 & 1074, Recover the reasonable value of medical care rendered for injuries or illnesses provided at the government's expense
- **DoD policy & guidance**
  - DoD 7000.14-R, DoD Financial Management Regulation (FMR)
  - DoD 6010.15-M, MTF UBO Manual
  - UBO Functional Business Rules

UBO Organization Chart



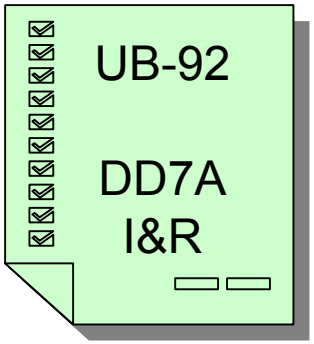
UBO Program Management
MTF Cost Recovery Programs

- **Third Party Collections Program (TPCP)**
  - Reimbursement from commercial insurers/health plans
    - DoD beneficiaries with Other Health Insurance (OHI) i.e. BC/BS, Aetna, etc.
  - MTF TPCP collections are above & beyond O&M funds
    - High visibility: GAO, DoD IG, Services' audits
- **Medical Services Accounts (MSA)**
  - DoD beneficiaries (i.e. subsistence charge, elective cosmetic procedures)
  - Non-DoD beneficiaries
    - Civilian emergencies (1st Party Payers)
    - Others authorized treatment in MTF (USCG, USPHS, VA, NOAA, DODDS overseas)
- **Medical Affirmative Claims (MAC)**
  - Recovery of costs to the federal government due to injuries for which a third party is responsible (formerly known as the third party liability program)
    - Billing of liability insurance: automobile, products, premises, homeowners, malpractice (civilian provider), workers' comp
  - Program management by the Recovery Judge Advocate
    - MTF responsible for MAC injury/claim identification and claim generation

UBO Program Mgmt – Cont'd
Outpatient Itemized Billing (OIB)

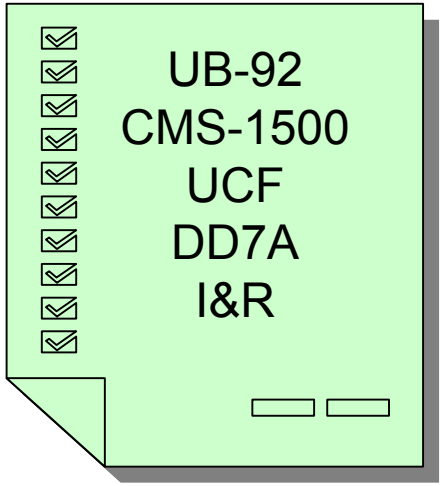
Pre- OIB
All-inclusive rate

MEPRS → Flat Rate



OIB Implementation (1 Oct 03)

- Itemized charges based on CPT/HCPCS codes
- Rates: CMAC-based
- Align with private sector billing practices
  - Professional services
  - Institutional charges
- Applies to all 3 UBO Programs



HIPAA 837 e-billing
*Deploying Feb 04 – Feb 05

Outpatient Itemized Billing (OIB) Challenges

- Medical Record Documentation
  - Documentation drives coding
  - Medical record availability (support coding; MTF/Third Party Payer audits)
- Coding
  - Reimbursement rates associated with CPT/HCPCS codes
  - Lack of certified/trained coding staff; billing backlog
- Reimbursement Rates
  - Initial rate package did not include institutional charges for ER, Observation & APV
    - ER & Observation institutional charges added to May 2003 rate package update
    - APV solution pending (Jan 04 rate package)
- Increased workload
  - Several itemized bills linked to a clinical encounter
    - Separate claims for clinical, ancillary & pharmacy
- Billing system issues
  - Composite Health Care System (CHCS): MSA, TPCP
  - Third Party Outpatient Collections System (TPOCS): TPCP
  - Manual process: MAC

Third Party Collections

Objectives

- General Information
- Regulations
- Insurance Identification
- Insurance Verification
- Rates
- Billing
- Follow-up
- Collecting
- Reporting

General Information

- TPC is a congressionally mandated program
- Established in 1986 for reimbursement of inpatient care
- Intent is to recover funds from insurance carriers based on services provided to certain military beneficiaries that have OHI
- Expanded in 1992 to include outpatient and ancillary services
- Expanded in 2002 to include itemization of outpatient and ancillary services

Regulations

- Title 10 USC, Section 1095 provides authority for the military to collect
- 32 CFR, Part 220 further defines authority and requirements
- DoD 6010.15-M provides guidance for TPC activities
- Individual Service (AF, USA, USN) guidelines
- Local MTF guidelines

Regulations

- Title 10 USC., Section 1095 provides the authority for military facilities to collect, for the cost of medical services from third party payers, on behalf of retirees and family members.
- 32 CFR is the regulation that further defines the authority and requirements for the TPC program.
- Part 220.1 – 220.14
- Each part addresses different aspects of the program
- Most frequently used document when dealing with insurance carrier payment issues.
- Published when changes are recommended

Regulations

- DoD 6010.15-M provides guidance for the operations of the Uniform Business Office to include TPC activities in Chapter 4.
- Addresses procedures for insurance identification, billing, follow-up, collecting and reporting activities.

Tips for Success - Print the regulations, highlight specific areas, and store in a continuity book for easy reference

Insurance Identification

- Timely and accurate identification of OHI crucial
  - Critical to success
  - Foundation needed to build
- Patient queried at each encounter for OHI
- OHI does not include Medicare Replacement Plans, Medicaid, TRICARE, and TRICARE or CHAMPUS Supplements
- OHI does include employer groups, comprehensive individual health plans, and Medicare supplemental plans

Insurance Identification

- Insurance information is captured on a DD Form 2569
- Form filled out on annual basis or when information changes
- Filed in the medical record
- Inpatient care requires the form be completed for each episode of care and filled in the inpatient record

Insurance Verification

- DD Form 2569 is forwarded to the TPC office for review
- Verification is completed before filing in the medical record
- Validation of coverage and benefits must be obtained prior to entering policy information in CHCS

Tips for Success – Use the TPOCS policy remarks section to store benefit (co-payments, deductibles, pharmacy coverage) information for easy reference when billing and posting

Rates

- Authorized rates are published by the DoD Comptroller
  - Only those rates may be used
- Rates are normally updated on an annual basis
- UBO uses CMAC table as primary rate table
- CMAC table is divided into 90 different locality codes
  - To account for geographical cost and expense differences
  - Locality codes correspond to zip codes of MTF DMIS ID

Rates

- Seven rate tables
  - CMAC
  - Ambulance
  - Anesthesia
  - Dental
  - DME/DMS
  - Immunizations/Injections
  - NDC

Tips for Success – Check TPOCS website for rate and table upgrades

Billing

- Billing for inpatient care is required within 10 days of encounter completion
- Billing for outpatient care is required within 7 days of encounter completion
- Billing is normally completed on a UB-92, CMS 1500, and UCF
- Bills upload from CHCS
- Errors are reflected on a "Load Error Report"

Tips for Success – Research the "Load Error" report and correct discrepancies in order to finalize bills

Follow-Up Activities

- Written or verbal follow-up is completed at 30 or 60 days of the initial claim
  - If done verbally, then a record of the contact (date, point of contact, action) must be documented
- Verbal follow-up most effective but most time consuming

Follow-Up Activities

- Transfer claim for legal action after 180 days from initial billing unless reasonable expectation of collection
- No longer than 270 days past initial billing
- Must have 2 documented follow-up attempts, reason for denial, original claims and any correspondence

Tips for Success – Use available on-line claims verification software when available to improve follow-up efficiency

Collecting

- Responsible for ensuring the payment received is correct
- Payment must be validated
- Must understand authority for collecting and predetermined valid reasons for denial
  - Amount of coverage
  - Care not covered
  - CHAMPUS and/or income supplemental plans
  - HMO
  - No utilization review
  - Patient co-payments and deductibles

Collecting

- Initially assume that any reduction made by the carrier is not valid
- If the amount not paid legitimately falls into one of the predetermined reasons the claim may be closed
- Any amounts not paid by the carrier,either valid or invalid, is never balanced billed to the patient.

Tips for Success – Obtain plan brochures to validate denials for non-covered services

Reporting

- TPOCS Reports:
  - DD Form 2570
  - Accounts Receivable
  - Activity
  - Tracking
  - Summary By Clinic
  - Positive and Negative Balance
  - Load Error
  - Adhoc

Reporting

- CHCS Reports
  - DD Form 2570
  - Accounts Receivable
  - Notify Roster
  - Payment Log
  - Print Queue Roster
  - Negative Balance
  - Write Off
  - Clinical Records Pending

Tips for Success – Use the Adhoc function to create reports for analyzing data

Wrap Up

- General Information
- Regulations
- Insurance Identification
- Insurance Verification
- Rates
- Billing
- Follow-up
- Collecting
- Reporting

Resources

- Title 10 USC, Section 1095
- 32 CFR, Part 220
- DoD 6010.15-M
- Individual Service
- Local MTF guidelines

Discussion

Uniform Business Office (UBO)
MTF Cost Recovery Programs

DoD Reimbursement Rates

Professional & Institutional Charges

DoD Reimbursement Rates Overview

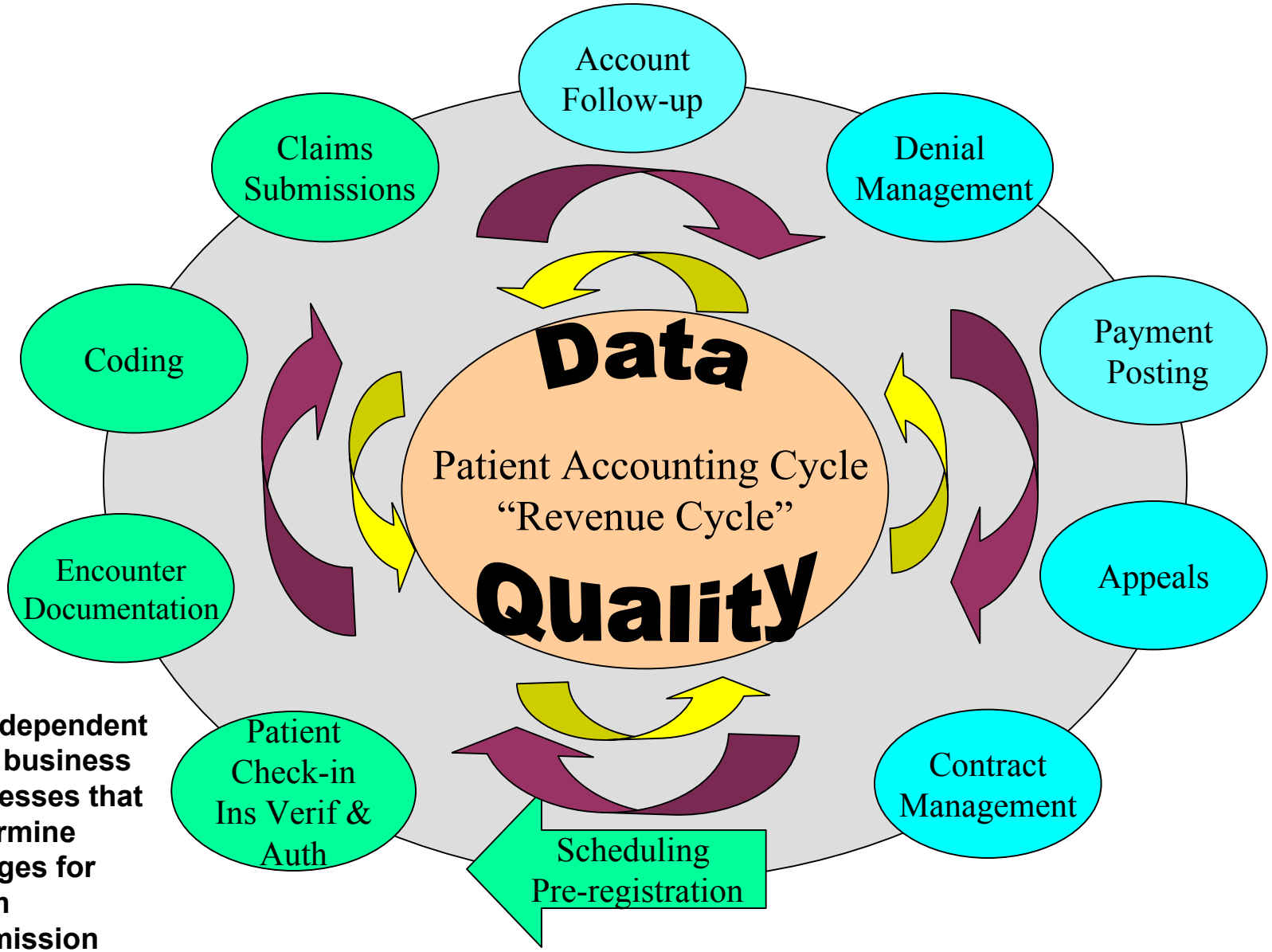
- MTF Revenue Cycle
- Professional & Institutional Charges
  - Inpatient Services
  - Ambulatory Services
    - Emergency Room (ER)
    - Observation (OBS)
    - Ambulatory Procedure Visit (APV)
  - Outpatient Clinic
  - Ancillary Services
    - Laboratory (LAB)
    - Radiology (RAD)
  - Outpatient Pharmacy Services

MTF = multiple roles as a "provider" of healthcare services

Challenge: claims submission that mirrors private sector practices;

Goal: acceptance by payers to improve MTF collections
TPCP, MSA, MAC

MHS Patient Accounting "Revenue" Cycle



Interdependent MTF business processes that determine charges for claim submission

MTF Revenue Cycle

- Patient administration
  - Beneficiary demographics
  - Other Health Insurance (OHI) identification, validation & file maintenance
  - Patient Category (PATCAT) code
- Encounter documentation
  - Documentation drives coding
  - Injury identification (MAC)
- Coding
  - Outpatient & ambulatory services
    - Reimbursement rates are assigned to CPT & HCPCS codes
  - Inpatient services
    - Assigned DRG (Encoder grouper)
- Claims generation/submission
  - Outpatient & ambulatory services
    - Professional services charges: CMS 1500
    - Institutional charges: UB-92
    - Electronic transmission for HIPAA 837 transaction
  - Inpatient services
    - All charges print to UB-92

HIPAA: Injury ID (outpt)
ADM, PGUI; CHCS II (pending)

DoD Reimbursement Rates

CMS - 1500

- Professional Charges
  - Rates reflect the charges for professional services provided by the privileged provider
    - Physicians
    - Nurse Practitioners
    - Physician Assistants
    - Other

UB - 92

- Institutional Charges
  - Rates reflect the charges for the facility's expenses in support of the services provided
    - Nursing services
    - Medical supplies
    - Ancillary & Pharmacy services provided in support of procedure/visit
    - Overhead facility costs

Inpatient Rate/Charge Development

- One rate
  - Contains both professional & institutional services
    - Adjusted Standardized Amount (ASA) rates
      - MEPRS-based
      - DoD Comptroller additives included
        - » i.e. MILPERS, CIVPERS, Accession costs
      - MTF specific
  - Rate calculation: ASA X DRG
    - One claim form: UB-92
      - Professional charges approximately 4% of total charge

Inpatient Rate/Charge Development – cont'd

- Inpatient Itemized Billing: in development
  - Separate professional & institutional charges
    - Professional services = CMS 1500
      - Physician services: rounds, consults
      - Evaluating Industry Based Workload Alignment (IBWA) system to capture professional workload & generate professional charges and claim generation
    - Institutional services = UB-92
      - Evaluation ASA rates used/published by the TRICARE Program for reimbursement of private sector services
        - » TRICARE ASA represents the institutional charge only

Timeline: IBWA full implementation; CMBB – use of revenue codes & place of service to generate appropriate institutional charges.

Ambulatory Services: ER & OBS

- Professional charges: MD, NP, PA
  - CHAMPUS Maximum Allowable Charge (CMAC)
    - Center for Medicare & Medicaid Services (CMS) based; non-facility practice expense relative value unit (RVU)
  - CMAC rate assigned to corresponding CPT codes
    - Evaluation & Monitoring (E&M) codes

Ambulatory Services: ER & OBS – continued

- Institutional charges = facility expenses
  - Initially not included in rate package released with Outpatient Itemized Billing (OIB) implementation (1 Oct 02)
  - Short-term/interim fix: 1 May 03 – present
    - Used Veterans Administration (VA) institutional rates for ER & OBS
    - Added to CMAC-rate resulting in a single rate assigned to the ER and OBS E&M codes
      - Systems limitation: CHCS & TPOCS requirements did not include need for an additional rate table; therefore, charges had to be combined
  - Long-term solution: System Change Request (SCR) submitted; requirements include use of 2nd rate table to support MTF institutional charges & separate claim generation
    - FY04 – unfunded
  - Final solution: Charge-Master Based Billing System
    - Acquisition FY04; Configuration/alpha test FY05
    - MHS deployment FY06-08

Ambulatory Services: APV

PROFESSIONAL CHARGES	INSTITUTIONAL CHARGES
Surgeon (Claim #1)	MTF – Facility (Claim #3)
Anesthesia (Claim #2)	

Private sector billing practices/insurance payers expectations for APV/Same Day Surgery claim submission include separate claim submission to support the surgeon's professional charges, the anesthesia provider's professional charges, and the facility's institutional charges.

APV Professional Charges: Surgeon

Encounter Coding	CMS 1500
• CPT code – procedure	Example: 52214-50 CMAC = $200 x 2 (50 modifier) Professional charges = $400

Currently UBO GFI CPT to Modifier Mapping Table directs code/charges to print on the UB-92; payers may interpret as the institutional charge.

TMA UBO to correct with GFI updates release along with rate table.

Need to validate if APV authorization number is included w/prof charge.

APV Professional Charges: Anesthesia Provider

Encounter Coding

- CPT code – anesthesia
- Payers directing that CPT procedure code needs to be included w/anesthesia

CMS 1500

00500 $174

(MEPRS - based)

ADM is not designed to capture minutes of service; therefore, a flat rate is used based on MEPRS data.

CY04 Outpatient rate table update (June release) – anesthesia flat rate is $731.

Currently, the anesthesia provider does not generate a separate CMS 1500. Proposed solutions: create APV bill type in TPOCS or use DMEPRS DFA clinic to capture anesthesia workload/encounter for billing. These solutions will also need to allow for an additional business rule to capture the CPT APV procedure code without generating a charge.

APV Institutional Charges

Encounter Coding

- *J - codes – anesthetic agents use during procedure
- APV facility fee

UB-92

*J7001	$25/unit
4 units used	$100 (CMAC x 4)
99199	$ 731
	$ **831**

APV facility fee will not be available until the CY04 Outpatient rate table update release (July - Aug 04).

APV facility fee = weighted average of the TRICARE Ambulatory Surgery Center (ACS) published rates for Fiscal Year 2004.
NOTE: ACS rate includes additive for anesthetic agents; therefore, J-codes will not be required to generate a charge.

APV: MTF Reimbursements

Current UBO Business Rules

CMS-1500	No charges
UB-92	*$ 400
	$ 100
Total reimbursement:	**$ 500**

* Represents professional charges

Corrective Actions & Business Process Improvements

CMS-1500 (surgeon)	$ 400
CMS-1500 (anesthesia)	$ 731
(institutional)	$ 731
Total reimbursement:	**$ 1,862**

Current UBO business rules only support claim generation for:

1) Capture the APV professional charges and the anesthesia J-codes.
2) These CPT/HCPCS codes print on the UB-92 (institutional claim form)

Outpatient Clinic

- Professional charges: MD, NP, PA
  - CHAMPUS Maximum Allowable Charge (CMAC)
    - Center for Medicare & Medicaid Services (CMS) based; non-facility practice expense relative value unit (RVU)
  - CMAC rate assigned to corresponding CPT codes
- Institutional charges
  - Part of the CMAC rate

Ancillary Services

- Laboratory & Radiology
  - Professional charges
    - CMAC rate assigned to CPT code/coding modifier used
  - Institutional charges
    - CMAC rate assigned to CPT code/coding modifier used
- Ancillary linkage issue
  - ADM encounter link to capture diagnosis
    - Increasing LAB/RAD file hold to allow ADM file completion; software enhancement will be available by the end of FY04
  - TPOCS merge to print all charges to 1 claim
    - Software to de-merge and allow separate claim forms for LAB and RAD services (available by the end of FY04)

Outpatient Pharmacy Services

- Charges assigned to pharmaceutical's National Drug Code (NDC#)
  - MTF Data Quality concern
    - NDC# ordered by provider may not be NDC# dispensed by the MTF pharmacy
      - NDC# ordered → sent to CHCS & TPOCS billing systems
- Reimbursement rate source
  - Managed Care Pricing File (MCPF)
    - Lowest Generic Cost currently used due to the data quality issue above
    - Dispensing Fee: MEPRS based ($7.00 next update)
- UBO Workgroup & TMA Pharmacy Benefits Division working solutions to billing issues

Other rates: MEPRS based
Ambulance, Immunization, etc

Questions?

DoD Reimbursement Rates: published rate package by DoD Comptroller Comptroller's website: effective date

MAC: Rate package additionally published in the Federal Register as tortuously liable rates.

Elective Cosmetic Surgery rates: new UBO policy/guidance to support calculation of charges up-front and produce bill for patient prior to procedure. Calculation will include professional/institutional charges r/t APV services.

Processing Denied Claims

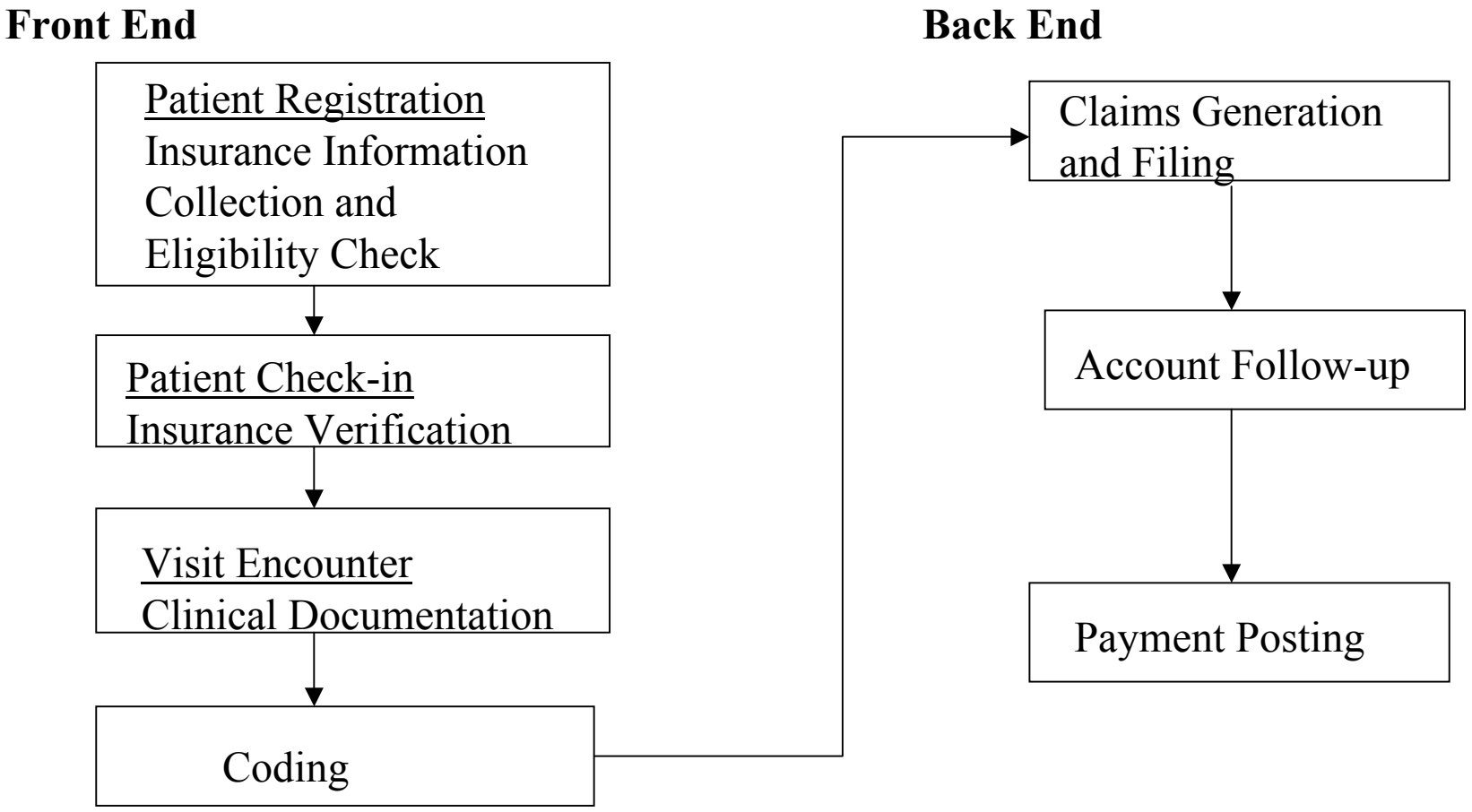
Objectives

- Revenue Cycle
- What is a Denied Claim
- Understanding the EOB
- Types of Denial Codes
  - Valid and Non Valid
- Organization
- Processing Denied Claims
- Record Keeping and Documentation
- Reducing Denials / Identifying Trends

Glossary

- EOB (Explanation of Benefits)
- COB (Coordination of Benefits)
- Clean Claim
- Front-end
- Back-end
- Adjudication
- Revenue Cycle
- KPIs (Key Performance Indicators)

Revenue Cycle: A Brief Review



What is a Denied Claim?

- Any claim, part or whole, that has not been paid to the fullest extent allowable by a payer for any reason that contradicts federal guidelines established through 10 U.S.C. 1095 and 32 C.F.R. 220.2.

Understanding the Explanation of Benefits (EOB)

- Patient name and group number
- Pt SSN, relationship to insured, member name
- Date of Service (DOS)
- Provider Name and Tax ID number
- Description of Service
- Itemized Amount billed, amount allowed, not covered, deductible and copay, amount paid to provider, patient responsibility, and remark codes

Understanding the EOB

- Submitting claims does not equal getting paid
  - Co-pay
  - Deductible
  - Maximum allowable charge
  - Denial codes

Types of Denial Codes

Valid

- HMO Plan, paid at PPO or out of network plan
- This service has been previously considered
- Request for additional information
- This procedure is not a covered benefit
- Timely filing not met
- Has not met deductible
- Waiting on Coordination of Benefits information

Types of Denial Codes

Non-Valid

- Processed as out of network provider
- Exceeds PPO contracted rate
- Amount billed exceeds usual and customary rate
- Copy of Medicare EOB Required in order to process.
- Claim processed as Secondary to Medicare Benefits
- Plan excludes MTFs
- Paid patient directly

Organize Your Work

- Develop a systematic approach to address denials
- Determine what work for you
  - By dollar amount of each denial
  - By payer
  - By denial type
  - Use a specific day for processing denials
- Helps identify denial trends

Processing the Denied Claim

- Determine reason claim was denied
  - May apply to a line item or to whole claim
- Research the denial issue
- Resubmit the claim with requested information
- Document your efforts
  - Telephone calls made to payers
  - Documents submitted
  - Final determination / outcome

Recordkeeping and Documentation

- Critical to establish an audit trail of steps taken to close a claim
- Key: If it is not documented, it did not happen!
- Includes:
  - Initial claim submission
  - DD2569
  - Copy of the insurance card
  - Clinical records
  - Follow-up conversations and documents provided to the payer

Strategies to Reduce Denials

- Work with the Payer
  - Develop a good relationship with the Payer CSR
- Educate the Payer
  - If the issue is beyond the scope of a CSR, get a Provider Relations Member involved
- Work with MTF staff
  - Provide revenue cycle staff with educational or training sessions to illustrate their impact
- Help yourself by helping your supervisor
  - Identify denial trends for your supervisor to address

Discussion

Sample
Non PPO Denial Letter

2-Jun-04

MEMORANDUM FOR «Ins_Co_Name»
«ins_Address_1»
«Ins_Address_2»
«Ins_City» «Ins_State» «Ins_Zip»

FROM: Your Facility
Third Party Collections
Address
City, State, Zip

SUBJECT: Status of Payment
RE: «Pt_First_Name» «Pt_Last_Name», Policy # «Policy_», Date of Service «DOS», Amount Billed «M__Billed», Amount Credited «Total_Credits», Total Remaining Balance «Balance», Our Control # «Control_Number».

1. Please note the attached documentation concerning the above referenced claim that has apparently been denied because the _____ is not a participating provider in your provider network.

2. In accordance with 10 U.S.C. § 1095 (part of the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272, Section 2001 [a] [11), codified at 32 C.F.R. § 220, et seq., third party payers pursuant to insurance, medical service, or health plan agreements are obligated to reimburse the United States "...the reasonable cost of...medical...care provided by facilities of the uniformed services to...beneficiaries who are also participants in the third party payer's health plan.

3. Furthermore, "the lack of a participation agreement or the absence of privity of contract between the third party payer and a facility...is not a permissible ground for refusing or reducing the third party payment. Also, our current price methodology must be considered for all outpatient services--i.e., the rate structure for the "aggregate group of services...or similar specialty group..." rather than the specific service rendered. Your Company, however, may challenge our charges by "...satisfactorily demonstrate[ing] a prevailing rate of payment in the geographic area for the same or similar **aggregate group** of [medical] services that is less than [our outpatient rate structure]..." by providing to us your prevailing rate schedule contractually entered into with other facilities or providers (other than managed care organizations) in the same geographical area, for review by our attorneys and statisticians. Documentation must include sample size, sample area, sample selection, grouping methodology, group mean, group standard deviation, confidence interval and other, subsequently, requested relevant factors. In the absence of such proof, full payment is expected.

4. Please provide payment or advise us of your processing status immediately. Payment may be made payable to: the _____. Please reference our control # «Control_Number» when issuing payment or any other correspondence. If you have any further questions we can be reached at _____. Your attention and cooperation in this matter is appreciated.

Third Party Collector

Attachment:
1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.3 (c) (4) (No Participation Agreement)
3. 32 C.F.R. 220.7 (Remedies and procedures)
4. 32 C.F.R. 220.8 (Reasonable Costs)
5. 32 C.F.R. 220.12 (Special rules for preferred provider organizations)
6. 32 C.F.F. 220.12 (c) (PPO Agreement not required)
7. Copy of original claim

Sample
MSP Denial Letter

2-Jun-04

MEMORANDUM FOR «Ins_Co_Name»
«ins_Address_1»
«Ins_Address_2»
«Ins_City» «Ins_State» «Ins_Zip»

FROM: Your Facility
Third Party Collections
Address
City, State, Zip

SUBJECT: Status of Payment

RE: «Pt_First_Name» «Pt_Last_Name», Policy # «Policy_», Date of Service «DOS», Amount Billed «M__Billed», Amount Credited «Total_Credits», Total Remaining Balance «Balance», Our Control # «Control_Number».

1. Please note the attached claim and documentation. You have apparently applied a Medicare Secondary Payer policy/plan provision to our claim--reducing our payment by what you calculate would have been Medicare's primary financial obligation.

2. The Medicare Secondary Payer (MSP) statutory information may be found at Social Security Act, section 1862(b), codified at 42 U.S.C. § 1395y; and, implementing regulations can be located at 42 C.F.R. §§ 400 and 411. Please note, "Medicare is the secondary payer to group health plans that cover aged [age 65 & older] individuals [and those under age 65 who are disabled or have end stage renal disease] who have current employment status with an employer, and aged spouses of individuals of any age who have current employment status with an employer." (60 FR 45345 [Thursday, August 31, 1995]). Medicare, by constructive implication, is the primary payer for health care services provided by **Medicare participating providers** to retired persons and their retired spouses.

3. The MSP coordination guidelines only apply to health care services rendered by a Medicare participating provider to an individual actually **enrolled in Medicare** and covered by an employer group health plan. As a federal agency, the Department of the Defense (DoD--including the Department of the Air Force) does not bill or coordinate benefits with another federal agency, i.e., the Health Care Financing Administration (i.e., Medicare). Please note 32 C.F.R. § 220.6(a), as follows: Under 10 U.S.C. § 1095(d), claims for payment from the Medicare or Medicaid programs Titles XVIII and XIX of the Social Security Act) are not authorized.

4. There are no payments of benefits by Medicare to federal DoD MTF's; consequently, there are no Medicare payments to coordinate with your plan benefits; thus, your plan benefit coordination provision is void ab initio or ineffectual as to DoD MTF claims and subsequent payments by your employer group health plan.

5. 32 C.F.R. § 220.3(c) asserts that health care plans cannot discriminate against uniformed services health care facilities by reducing payment by what the payer considers to be the Medicare primary payment--unless, the applicable health plan provision expressly disallows payment as the primary payer to all providers to whom payment would be made under Medicare (including payment under Part A, Part B, a Medicare HMO or a Medicare+Choice plan) and is otherwise in accordance with applicable law. We are requesting that your organization immediately stop discriminating against our facilities.

6. The National Association of Insurance Commissioners (NAIC) Group Coordination of Benefits Model Regulation, adopted in similar format by all of the states incorporates the MSP guidelines. Note, In coordinating benefits between plans, the carrier shall follow the order of precedence established by the NAIC Model Guidelines for Coordination of Benefits (COB) as specified by OPM. (48 C.F.R. § 1652.204-71[c]).

7. Medicare is prohibited from paying DoD! Again, there is nothing to coordinate with! Also, the NAIC acknowledges that the MSP guidelines are coordination (with employer group health plans) rules for Medicare participating providers. NAIC representatives stated in a phone conversation, that the COB provisions as related to Medicare are inapplicable to DoD reimbursements.

8. We do not recognize the validity of your MSP provision as applied to our claims. Applying the same discriminates against federal health treatment facilities. I am requesting immediate payment of the above-referenced amount due. Payment may be made payable to: _____ and forwarded to the above address with the appropriate explanation of benefits attached. Please reference our control number «Control_Number» when issuing payment or any other correspondence. If you have any further questions we can be reached at _____.

Third Party Collector

Attachment:
1. Copy of original claim
2. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
3. 32 C.F.R. 220.3(c)(5) (Medicare carve-out and Medicare secondary payer provisions.)
4. 32 C.F.R. 220.6(a) (Medicare and Medicaid)
5. 32 C.F.R. 220.10 (Special Rules for Medicare Supplemental Plans)
6. 32 CFR 220.7 (Remedies and procedures)

Sample Appeal Payment Sent To The Insured

2-Jun-04

MEMORANDUM FOR «Ins_Co_Name»
«ins_Address_1»
«Ins_Address_2»
«Ins_City» «Ins_State» «Ins_Zip»

FROM: Your Facility
Third Party Collections
Address
City, State, Zip

SUBJECT: Payment of Medical Claim

RE: «Pt_First_Name» «Pt_Last_Name», Policy # «Policy_», Date of Service «DOS», Amount Billed «M__Billed», Amount Credited «Total_Credits», Total Remaining Balance «Balance», Our Control # «Control_Number»

1. Please note the attached documentation. The above referenced claim has been previously denied based on the fact that your Company paid the insured.

2. In accordance with 10 U.S.C. § 1095 (part of the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272, section 2001 [a] [1]), codified at 32 C.F.R. § 220, et seq., third party payers are obligated to reimburse the United States "...the reasonable cost of...[medical services]... provided by facilities of the uniformed services to...beneficiaries who are also participants in the third party payer's health plan." **Furthermore "the only way for a third party payer to satisfy its obligation under 10 U.S.C., section 1095 is to pay the [military] facility" not the insured. Finally, "payment by a third party payer to the beneficiary does not satisfy 10 U.S.C., section 1095."**

3. Please provide payment to our facility immediately. Payment must be made payable to: _____. Please reference our control # «Control_Number» when issuing payment or any other correspondence. If you have any further questions we can be reached at _____. Your attention and cooperation in this matter is appreciated.

Third Party Collector

Attachment:
Copy of Original Claim
32 CFR 220.2 (a) & (c)

Sample
MCR EOB Requested to Process Claim

MEMORANDUM FOR «Ins_Co_Name»
«ins_Address_1»
«Ins_Address_2»
«Ins_City» «Ins_State» «Ins_Zip»

FROM: Your Facility
Third Party Collections
Address
City, State, Zip

SUBJECT: Status of Payment

RE: «Pt_First_Name» «Pt_Last_Name», Policy # «Policy_», Date of Service «DOS», Amount Billed «M__Billed», Amount Credited «Total_Credits», Total Remaining Balance «Balance», Our Control # «Control_Number».

Claims Processor,

We have recently received a request by you to provide a copy of the Medicare Explanation of Benefits for the above listed claim. Please note that the _____ is a Department of Defense Facility.

As a federal agency, the Department of the Defense (DoD--including the Department of the Air Force) does not bill or coordinate benefits with another federal agency, i.e., the Health Care Financing Administration (i.e., Medicare). Please note 32 C.F.R. § 220.6(a), as follows: Under 10 U.S.C. § 1095(d), claims for payment from the Medicare or Medicaid programs Titles XVIII and XIX of the Social Security Act) are not authorized.

There are no payments of benefits by Medicare to Federal DoD Military Treatment Facilities; consequently, there are no Medicare Explanations of Benefits. Please note that, in accordance with 32 C.F.R. 220.10(d) …A Medicare Supplemental plan may not refuse payment to a claim…on the grounds that no claim had previously been submitted…for payment under the Medicare program.

We request that you resume the processing of this claim immediately. Payment may be made payable to: _____ and forwarded to the above address with the appropriate explanation of benefits attached. Please reference our control number «Control_Number» when issuing payment or any other correspondence.

Hopefully, this letter has sufficiently explained the status of our facility. We further request that you update your records to indicate that the _____ is a Federal, Department of Defense, Facility. Furthermore please alert your claims processing staff of our status to ensure the claims of the _____ are processed without any unnecessary delays. Thank you for your prompt attention. Should you have any further questions we can be reached at _____.

Sincerely,

Third Party Collections

Sample
CFR Cheat Sheet

Medicare Secondary Payer (MSP) / Medicare Carve Out

1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.3(c)(5) (Medicare carve-out and Medicare secondary payer provisions.)
3. 32 C.F.R. 220.6(a) (Medicare and Medicaid)
4. 32 C.F.R. 220.10 (Special Rules for Medicare Supplemental Plans)
5. 32 CFR 220.7 (Remedies and procedures)

Non-Preferred Provider (Non PPO)

1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.3 (c) (4) (No Participation Agreement)
3. 32 C.F.R. 220.7 (Remedies and procedures)
4. 32 C.F.R. 220.8 (Reasonable Costs)
5. 32 C.F.R. 220.12 (Special rules for preferred provider organizations)
6. 32 C.F.F. 220.12 (c) (PPO Agreement not required)

Usual and Customary Allowance (U&C)

1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.3 (c) (4) (No Participation Agreement)
3. 32 C.F.R. 220.7 (Remedies and procedures)
4. 32 C.F.R. 220.8 (Reasonable Costs)
5. 32 C.F.R. 220.12 (Special rules for preferred provider organizations)
6. 32 C.F.F. 220.12 (c) (PPO Agreement not required)

Payment sent to Insured

1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.2 (c) (Paying Patient does not satisfy obligation)
3. 32 C.F.R. 220.2 (d) (Assignment of Benefits Not Necessary)
4. 32 C.F.R. 220.2 (e) (Preemption of State Law)

Denied Government Facility

1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.3 (a) (Statutory requirement)
3. 32 C.F.R. 220.3 (b)(3) (Cannot treat claims from Government Facility less favorably)
4. 32 C.F.R. 220.3 (c)(1) (Cannot deny/reduce services provided or paid for by government facility)

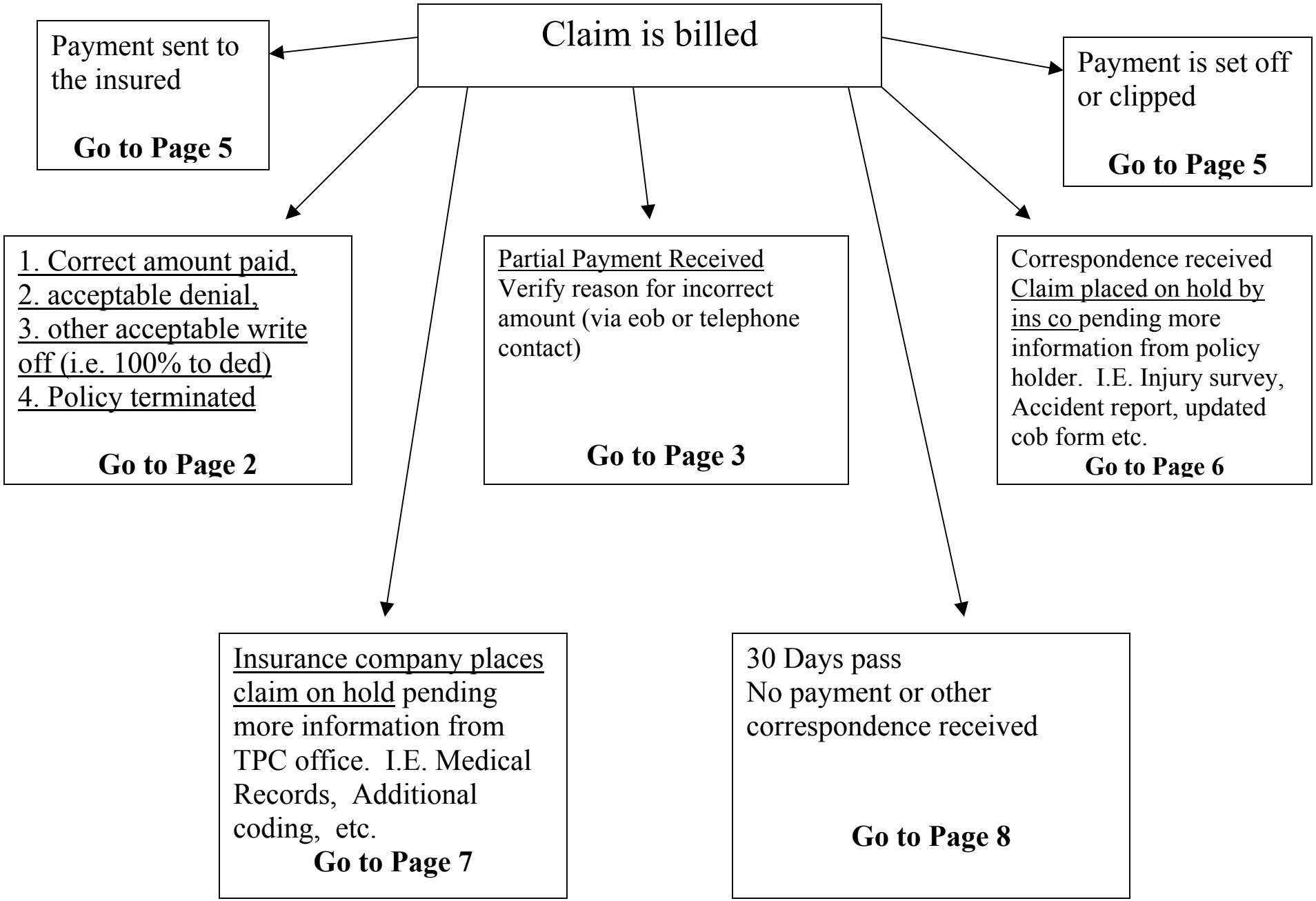
Recoupment / Set Off / Take Back

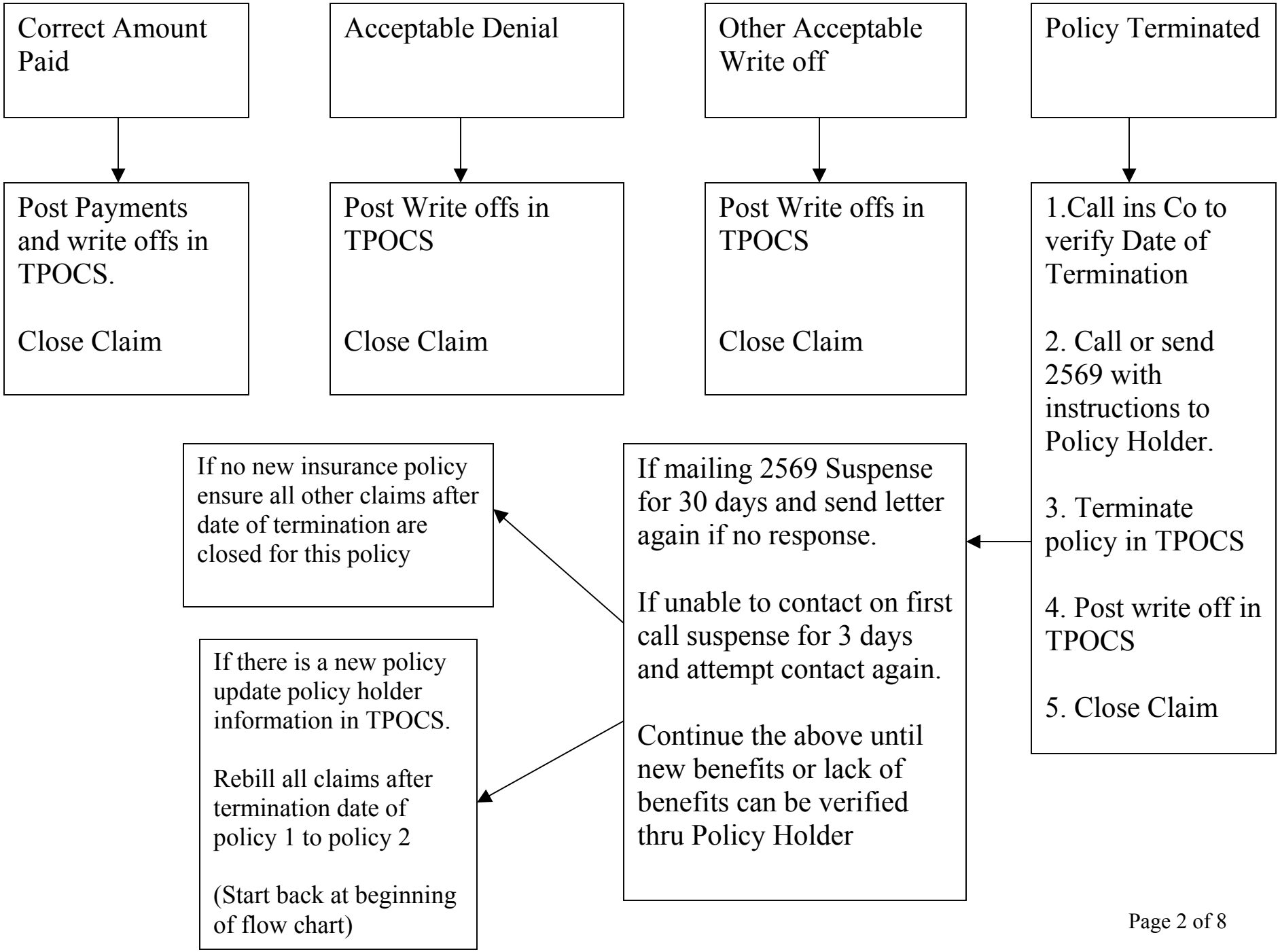
1. Copy of 32 CFR 220.7 (a) thru (d)

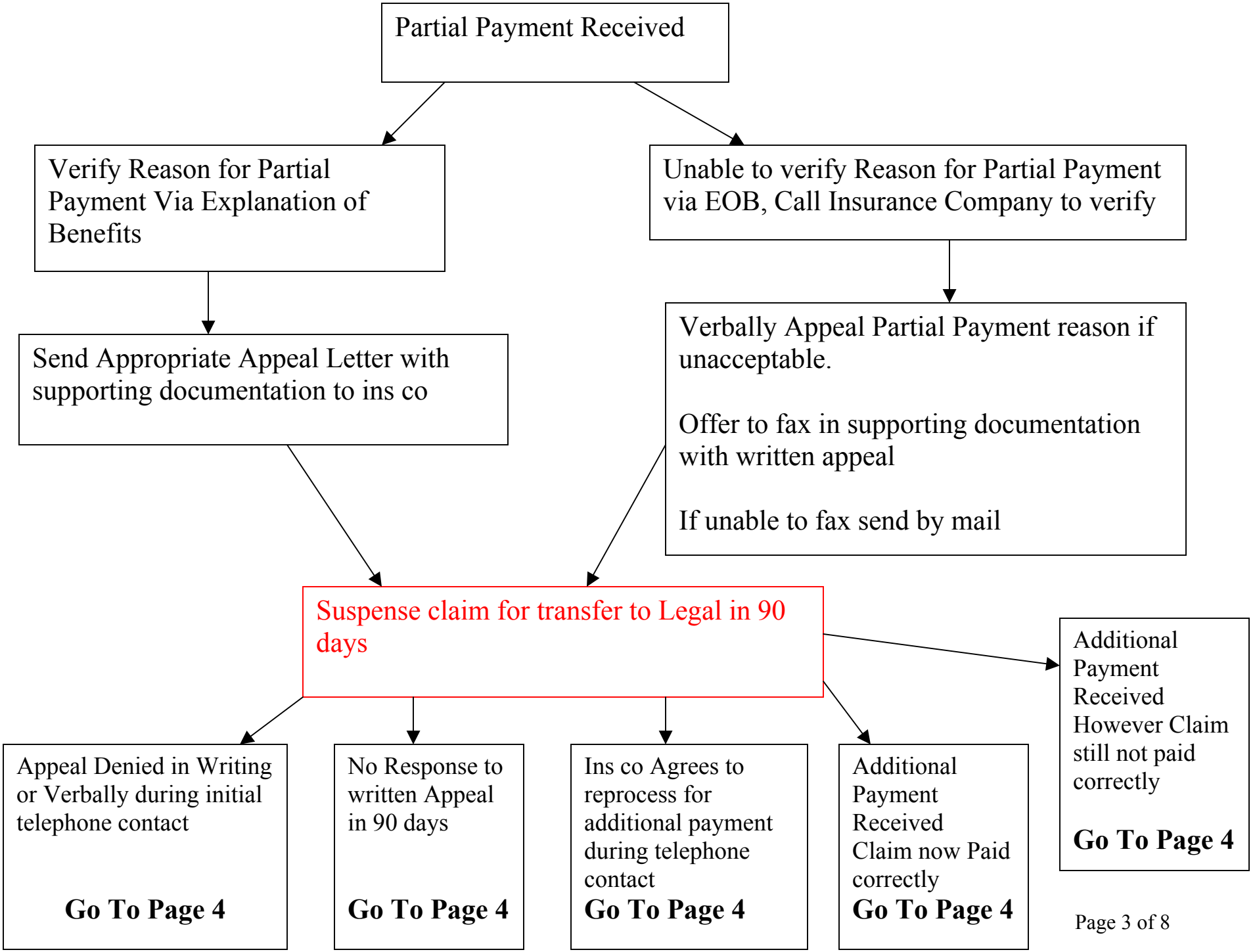
Medicare EOB

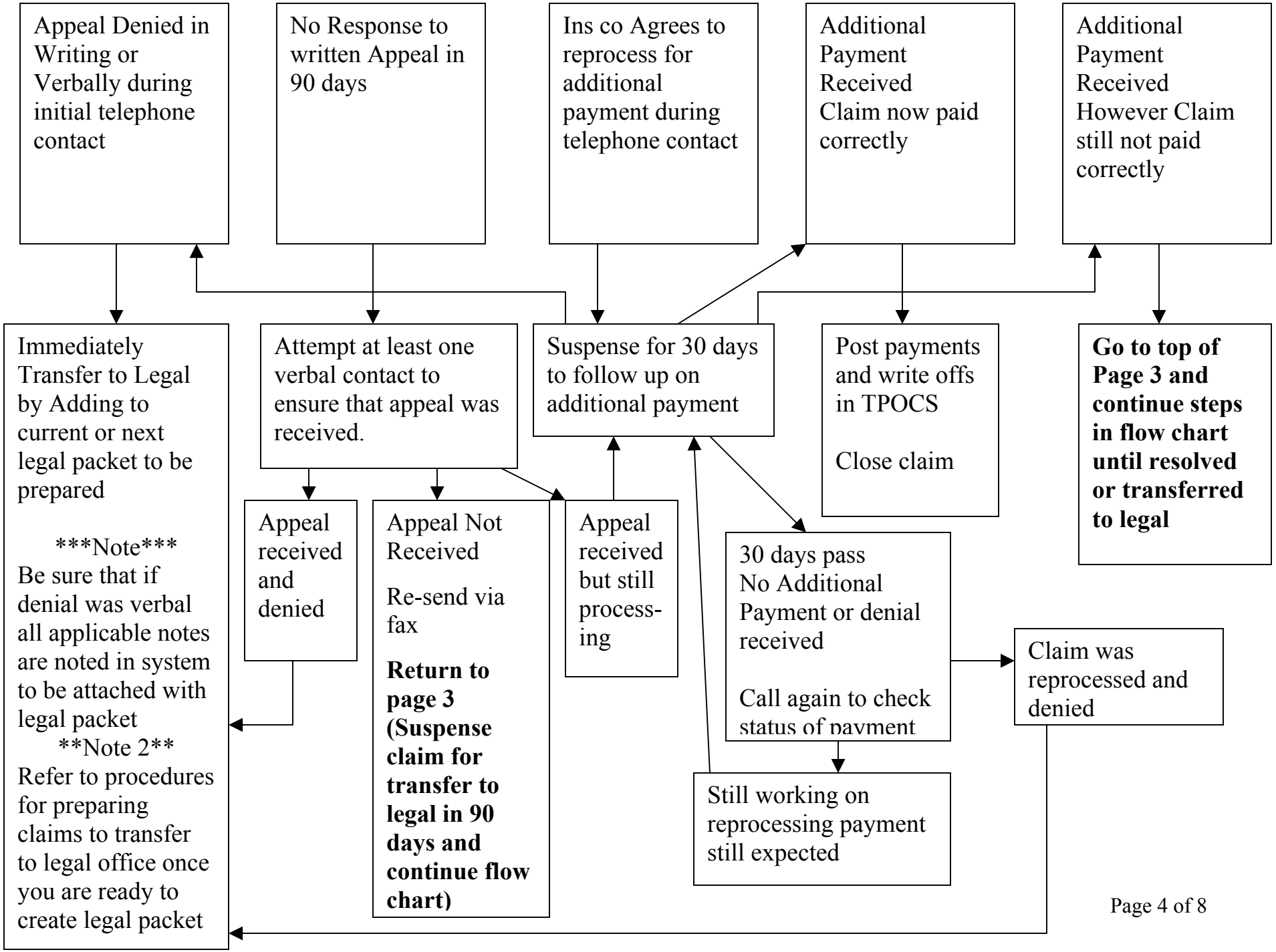
1. 32 C.F.R. 220.2 (a) (Statutory obligation of third party payer to pay)
2. 32 C.F.R. 220.6(a) (Medicare and Medicaid)
3. 32 C.F.R. 220.10 (d) (Medicare claim not required)

FEP PLANS: NON COVERED BENEFITS		
APWU	*Vision*	No routine coverage. Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery are not covered.
	Foot care	No routine. Exception when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.
	Hearing tests	Hearing aids, testing and exams for them are not covered.
	Prescription	No vitamins, minerals, nutritional supplement or OTC.
BCBSFEP	*Vision*	No routine coverage. Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery are not covered
	Foot care	No routine. Exception when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes
	Hearing tests	No routine with the exception of under preventative care for children.
	Prescription	No OTC. Drugs for weight loss or infertility are not covered.
GEHA	*Vision*	No routine coverage. Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery are not covered
	Foot care	No routine. Exception when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes
	Hearing tests	Hearing aids, testing and exams for them are not covered.
	Prescription	Vitamins and OTC not covered. Drugs for weight loss, infertility and impotence are not covered.
MHBP	*Vision*	No routine coverage. Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery are not covered
	Foot care	No routine. Exception when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes
	Hearing tests	Routine hearing tests, hearing aids, and related services when the hearing loss is not related to an accidental injury.
	Prescription	No OTC. Drugs for weight loss or impotence are not covered.
PBP	*Vision*	No routine coverage. Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery are not covered
	Foot care	No routine. Exception when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes
	Hearing tests	No routine hearing testing. No hearing aids, testing and examinations and batteries for them, except for accidental injury or surgery.
	Prescription	No OTC, vitamins, or drugs for smoking cessation.


Claim is billed
Payment sent to the insured
Go to Page 5
Payment is set off or clipped
Go to Page 5
1. Correct amount paid,
2. acceptable denial,
3. other acceptable write off (i.e. 100% to ded)
4. Policy terminated
Go to Page 2
Partial Payment Received
Verify reason for incorrect amount (via eob or telephone contact)
Go to Page 3
Correspondence received
Claim placed on hold by ins co pending more information from policy holder. I.E. Injury survey, Accident report, updated cob form etc.
Go to Page 6
Insurance company places claim on hold pending more information from TPC office. I.E. Medical Records, Additional coding, etc.
Go to Page 7
30 Days pass
No payment or other correspondence received
Go to Page 8


Correct Amount Paid
Acceptable Denial
Other Acceptable Write off
Policy Terminated
Post Payments and write offs in TPOCS.
Close Claim
Post Write offs in TPOCS
Close Claim
Post Write offs in TPOCS
Close Claim
1.Call ins Co to verify Date of Termination
2. Call or send 2569 with instructions to Policy Holder.
3. Terminate policy in TPOCS
4. Post write off in TPOCS
5. Close Claim
If mailing 2569 Suspense for 30 days and send letter again if no response.
If unable to contact on first call suspense for 3 days and attempt contact again.
Continue the above until new benefits or lack of benefits can be verified thru Policy Holder
If no new insurance policy ensure all other claims after date of termination are closed for this policy
If there is a new policy update policy holder information in TPOCS.
Rebill all claims after termination date of policy 1 to policy 2
(Start back at beginning of flow chart)


Partial Payment Received
Verify Reason for Partial Payment Via Explanation of Benefits
Unable to verify Reason for Partial Payment via EOB, Call Insurance Company to verify
Send Appropriate Appeal Letter with supporting documentation to ins co
Verbally Appeal Partial Payment reason if unacceptable.
Offer to fax in supporting documentation with written appeal
If unable to fax send by mail
Suspense claim for transfer to Legal in 90 days
Additional Payment Received However Claim still not paid correctly
Go To Page 4
Appeal Denied in Writing or Verbally during initial telephone contact
Go To Page 4
No Response to written Appeal in 90 days
Go To Page 4
Ins co Agrees to reprocess for additional payment during telephone contact
Go To Page 4
Additional Payment Received Claim now Paid correctly
Go To Page 4


Appeal Denied in Writing or Verbally during initial telephone contact
No Response to written Appeal in 90 days
Ins co Agrees to reprocess for additional payment during telephone contact
Additional Payment Received Claim now paid correctly
Additional Payment Received However Claim still not paid correctly
Immediately Transfer to Legal by Adding to current or next legal packet to be prepared
Note
Be sure that if denial was verbal all applicable notes are noted in system to be attached with legal packet
Note 2
Refer to procedures for preparing claims to transfer to legal office once you are ready to create legal packet
Attempt at least one verbal contact to ensure that appeal was received.
Suspense for 30 days to follow up on additional payment
Post payments and write offs in TPOCS
Close claim
Go to top of Page 3 and continue steps in flow chart until resolved or transferred to legal
Appeal received and denied
Appeal Not Received
Re-send via fax
Return to page 3 (Suspense claim for transfer to legal in 90 days and continue flow chart)
Appeal received but still process-ing
30 days pass No Additional Payment or denial received
Call again to check status of payment
Claim was reprocessed and denied
Still working on reprocessing payment still expected

Payment is Set off or Clipped

Call ins Co to appeal Set off / Clipping of payment

Offer to fax in supporting documentation including written appeal letter

If unable to fax send by mail

Note
You may need to insist on speaking to a supervisor on this or any other appeal issue

Go to page 3 (suspense claim for transfer to legal in 90 days)
and continue with flow chart.

Payment sent to insured

Call ins Co to appeal payment sent to insured

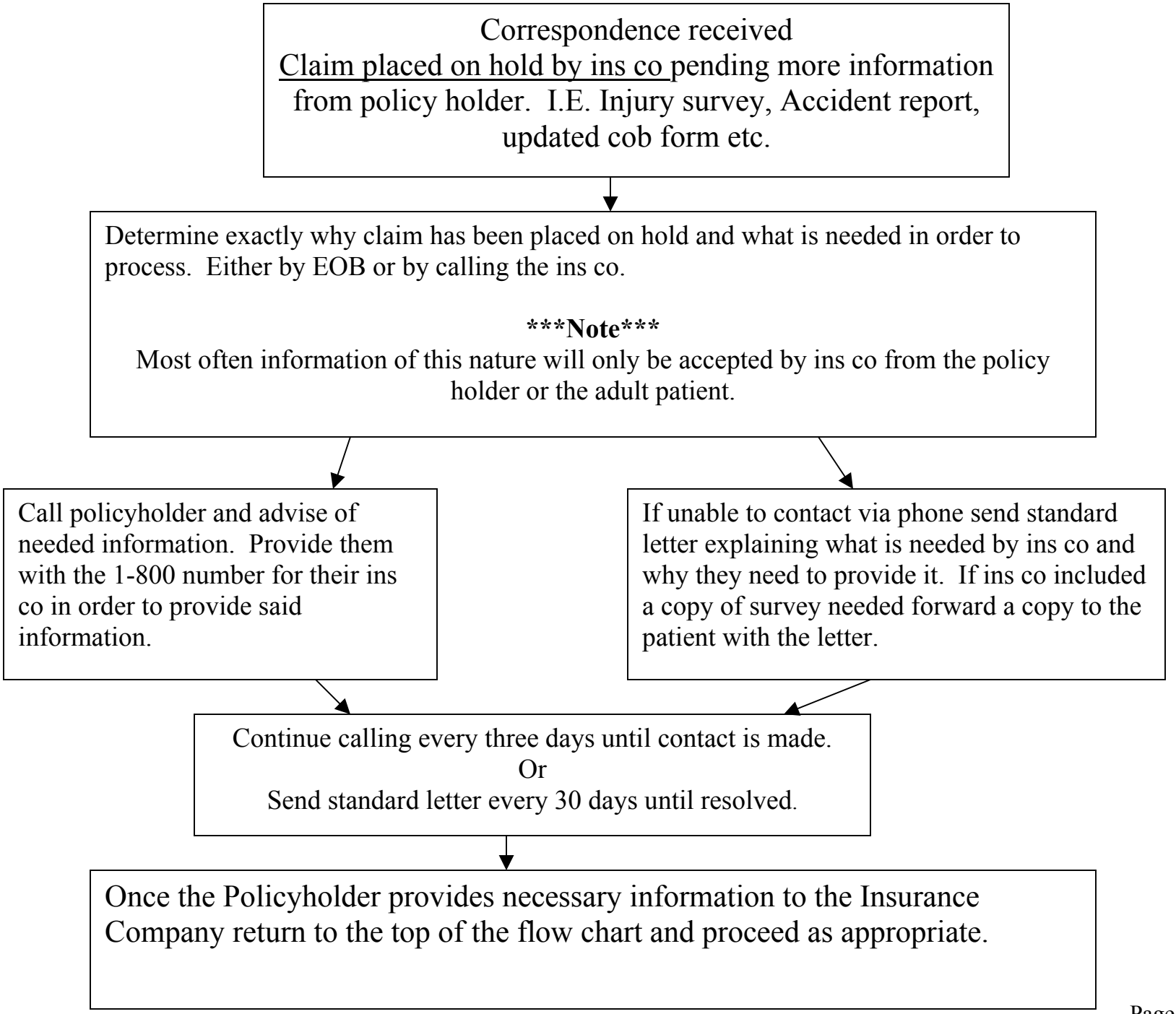
Offer to fax in supporting documentation including written appeal letter

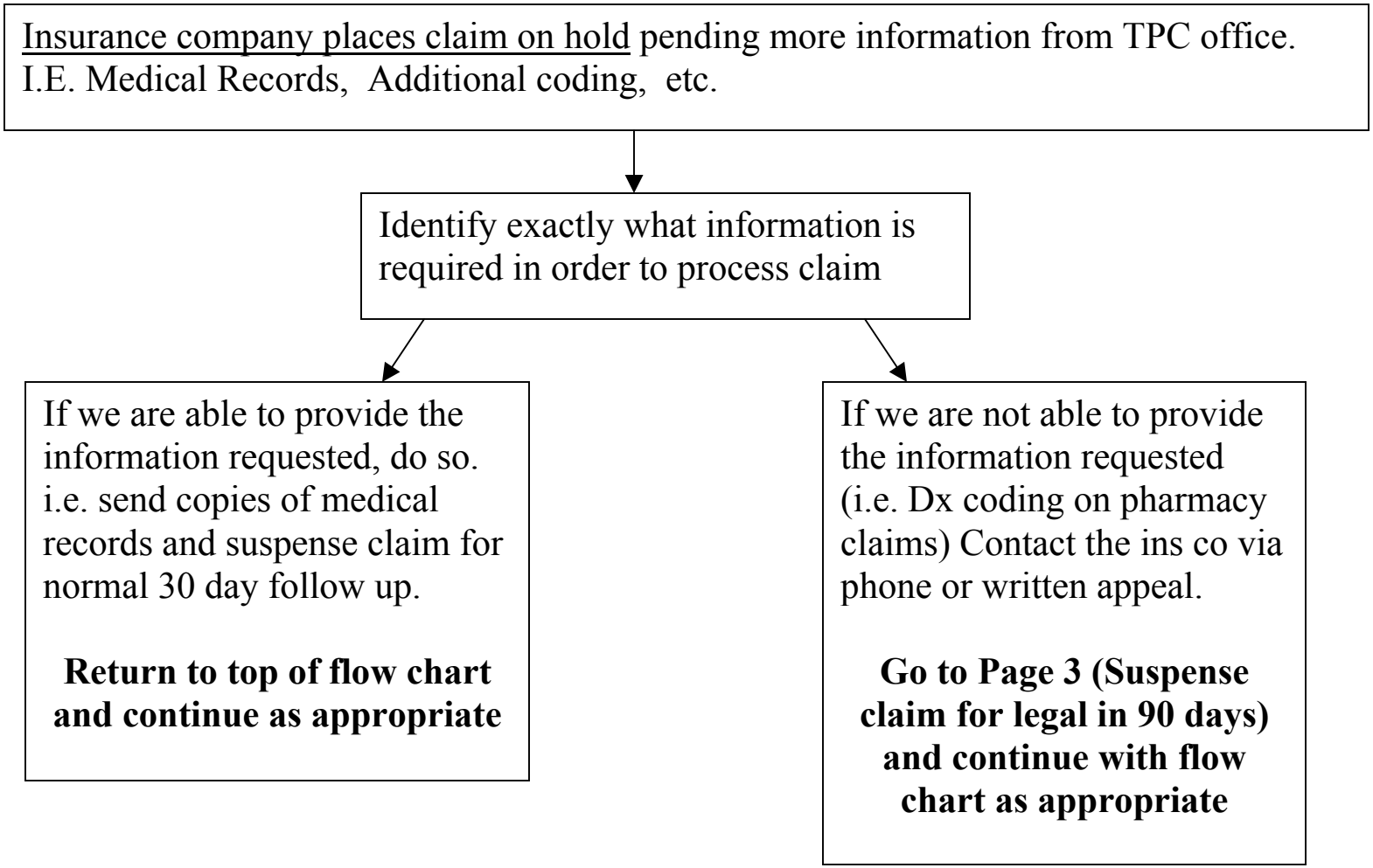
If unable to fax send by mail

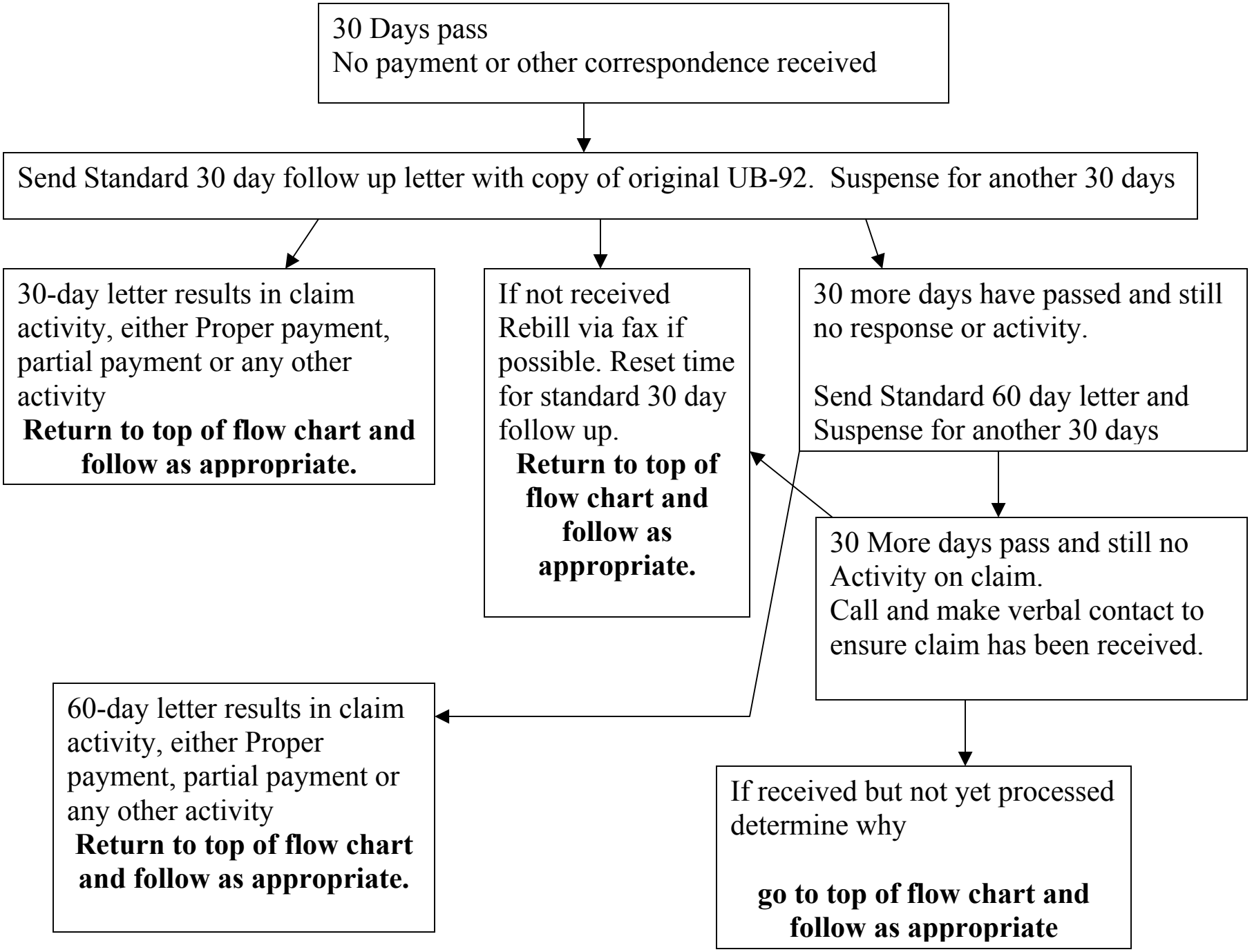
Note
You may need to insist on speaking to a supervisor on this or any other appeal issue

Call Policy Holder advise they cannot cash check and it must be brought in to TPC office or returned to ins co immediately if unable to contact by phone send standard letter explaining the above.

Note
You cannot collect from the patient. If payment has already been cash it is the ins co responsibility to re-issue payment to us and then collect from the policy holder


Correspondence received
Claim placed on hold by ins co pending more information from policy holder. I.E. Injury survey, Accident report, updated cob form etc.
Determine exactly why claim has been placed on hold and what is needed in order to process. Either by EOB or by calling the ins co.
Note
Most often information of this nature will only be accepted by ins co from the policy holder or the adult patient.
Call policyholder and advise of needed information. Provide them with the 1-800 number for their ins co in order to provide said information.
If unable to contact via phone send standard letter explaining what is needed by ins co and why they need to provide it. If ins co included a copy of survey needed forward a copy to the patient with the letter.
Continue calling every three days until contact is made.
Or
Send standard letter every 30 days until resolved.
Once the Policyholder provides necessary information to the Insurance Company return to the top of the flow chart and proceed as appropriate.


Insurance company places claim on hold pending more information from TPC office. I.E. Medical Records, Additional coding, etc.
Identify exactly what information is required in order to process claim
If we are able to provide the information requested, do so. i.e. send copies of medical records and suspense claim for normal 30 day follow up.
Return to top of flow chart and continue as appropriate
If we are not able to provide the information requested (i.e. Dx coding on pharmacy claims) Contact the ins co via phone or written appeal.
Go to Page 3 (Suspense claim for legal in 90 days) and continue with flow chart as appropriate


30 Days pass
No payment or other correspondence received
Send Standard 30 day follow up letter with copy of original UB-92. Suspense for another 30 days
30-day letter results in claim activity, either Proper payment, partial payment or any other activity
Return to top of flow chart and follow as appropriate.
If not received Rebill via fax if possible. Reset time for standard 30 day follow up.
Return to top of flow chart and follow as appropriate.
30 more days have passed and still no response or activity.
Send Standard 60 day letter and Suspense for another 30 days
30 More days pass and still no Activity on claim.
Call and make verbal contact to ensure claim has been received.
60-day letter results in claim activity, either Proper payment, partial payment or any other activity
Return to top of flow chart and follow as appropriate.
If received but not yet processed determine why
go to top of flow chart and follow as appropriate

Medical Services Accounts

Objectives

- General Information
- Regulations and Guidelines
- Internal Controls
- Medical Services
- Rates and Patient Categories
- Billing Forms
- Billing Process
- Delinquent Account Processing
- Collecting, Depositing, and Reporting

General

- Bills and collects for medical services and subsistence
- Services provided to DoD and Other Uniform Service beneficiaries, civilian emergencies, and others authorized treatment
- Payment is collected from both first and third party payers
- Funds are deposited in appropriate accounts
- Most functions are automated in CHCS

Regulations and Guidelines

- Title 10 USC, Section 1078 provides establishment of fair charges for medical and dental
- DoD 6010.15-M provides guidance for MSA activities
- DoD Functional Business Rules for Itemized Billing
- Individual Service (AF, USA, USN) guidelines
- Local MTF guidelines

Regulations

- Title 10 USC., Section 1078 prescribes the establishment of fair charges for medical and dental care.
- Rates published in Federal Register
- Inpatient charges are DRG-based and outpatient are itemized

Regulations

- DoD 6010.15M provides guidance operations of the Uniform Business Office to include MSA activities in Chapter 3 and guidelines for charges in Chapter 6
  - Addresses responsibilities of the MSA Officer, internal controls, appropriations and rates, billing, delinquent account processing, collecting, depositing, and reporting activities.

Tips for Success - Print the regulations, highlight specific areas, and store in a continuity book for easy reference

Internal Controls

- Primary and alternate cashiers are appointed in writing
- Alternate cashier will have separate lock box or cash draw
- Collections are reconciled at the end of each business day

Internal Controls

- Same person should not establish the accounts receivable and collect funds
- Change fund will be audited once per month
- Funds are secured in an approved storage container

Tips for Success - Establish a file that contains appointment letters and audit results for easy reference.

Medical Services

Chapter 6, DoD 6010.15M, Charges for Care and Subsistence

- Inpatient – DRG-based
- Ambulatory Procedure Visits – Itemized
- Outpatient – Itemized
  - Various services with established rate
- Subsistence
- Other administrative items (copy charges)

Patient Categories and Rates

Patient category will determine charge

- Complete list in CHCS, Patient Category Billing Table
- Five charge categories
  - SR (Subsistence Rate) – Active Duty
  - FR (Family Member Rate) – Family Members
  - IMET (International Military Education and Training) – Foreign Military
  - IAR (Interagency Rate) – Other Uniform Services
  - FRR (Full Reimbursement Rate) – Civilian Emergencies

Billing Forms

- Patient category will determine billing form
- Types of billing forms
  - I&R (Invoice and Receipt)
  - DD Form 7/7A, Report of Treatment Furnished to Pay Patients
  - SF 1080, Voucher for Transfers Between Appropriations and/or Funds
  - UB92, Uniform Bill

Billing Process

I&R

- Used for DoD beneficiaries (AD, FM, RET)
  - Reimbursement of inpatient medical services and subsistence charges (FM and SR rate)
  - Generated by the automated system
  - Payment is expected upon discharge
- Used for Non-DoD beneficiaries
  - Reimbursement for inpatient and outpatient services (FRR rate)
  - Inpatient charge is based on a DRG based calculation
  - Outpatient charge is itemized based on procedures
    - Charges may be appended or excluded
  - Payment for outpatient services is expected before care is rendered

Billing Process

- DD 7/7A
  - Used for Other Uniformed Services beneficiaries (CG, PHS, NOAA)
    - Reimbursement for inpatient and outpatient services (IAR)
    - Generated by the automated system
    - Prepared on a monthly basis
    - If OHI exists, first bill the insurance and then balance bill the agency
  - Foreign Nationals
    - Reimbursement for inpatient and outpatient services (IMET)
    - Billed to central agency, State Department, or as specified in members military orders
- SF 1080
  - Primarily used to bill Department of Veterans Affairs
  - Reimbursement for inpatient and outpatient services (IAR)

Billing Process

UB92

- Used for Non-DoD beneficiaries (State Department, civilian employees, civilian emergencies) who are covered by health insurance
- Reimbursement for inpatient and outpatient services (FRR)
  - Inpatient is a DRG based charge and outpatient is itemized by procedure
  - Claim form automatically generated for inpatient
- TPOCS can be used to generate outpatient claims
- Patients covered by Medicare will be billed to the Fiscal Intermediary at the IAR DRG rate

Tips for success – Check the Admissions Sheet and Emergency Room Log to ensure all billing has been completed on a daily basis

Delinquent Account Processing

- Every effort should be made to collect payment within 30 days of initial billing
- A delinquent letter should be sent 15 days after initial billing
- Process a DD Form 139 for first party debts 30 days after initial billing
- A payment plan may be set up
- Transfer the account at 180 days past initial billing to the Accounting and Finance office

Delinquent Account Processing

- For insurance collections, a follow-up should be conducted at 30 and 60 days after initial billing
- Collect payments from the patient if after 180 days the account remains unpaid
- Transfer the account at 180 days past initial billing to the Accounting and Finance office
  - Provide a copy of the bill and follow-up attempts

Tips for success – Include verbal follow-up as part of the delinquent processing. Consider accepting credit cards for payment, if authorized.

Collecting, Depositing, and Reporting

- Accounts that are not centrally reimbursed will be posted in the automated system
- A DD Form 1131 and SF 215 are prepared for depositing in the appropriate fund
- A Monthly MSA Report outlining billing and collecting activities will be prepared and submitted to the Finance Office

Summary

- General Information
- Regulations and Guidelines
- Internal Controls
- Rates and Patient Categories
- Billing Forms
- Billing Process
- Delinquent Account Processing
- Collecting, Depositing, and Reporting

Resources

- Title 10 USC, Section 1078
- DoD 6010.15M, Uniform Billing Office Manual
- DoD Functional Business Rules for Itemized Billing
- Individual Service (AF, USA, USN) guidelines
- Local MTF guidelines

MEDICAL AFFIRMATIVE CLAIMS

"MAC"

Today we will discuss

- What is a Medical Affirmative Claim (MAC)
- Your responsibilities as outlined in UBO manual issued under the authority of DOD instructions 6015.23
- How to comply
- Other elements of a successful MAC program
- Training Medical Group staff on MAC
- Creating bills
- Self-evaluation

What is the Medical Affirmative Claim Program?

A MAC program provides the statutory and regulatory authority to recover the reasonable value of medical care rendered for injuries or illnesses provided at government expense to active duty members, dependents (as defined at 10 U.S.C. 1072 (reference (o))), and retirees (as defined at 10 U.S.C. 1074(b) (reference (i)), under circumstances creating third party tort liability.

What is a Medical Affirmative Claim?

A MAC includes all forms of liability or tort-based insurance, such as liability relating to:

- Automobiles
- Boats and airplanes
- Manufacturers' defective products
- General casualty (e.g., slips and falls)
- Homeowners' and/or Renters' property
- Medical malpractice (other than Federal providers)
- Workers' Compensation (other than Federal employees)

How Does the MAC Program Benefit Your Facility?

- It creates revenue
  - All monies collected under this program are deposited directly into your facility's O&M account
  - The funds generated are later available as part of the hospital's fiscal year budget
  - The more money collected, the more money your hospital will have for renovation projects, updated medical equipment, computers, etc.

Your Responsibilities to Comply as Outlined in the UBO Manual slide1

- Screen admitting, emergency room, physical therapy, and outpatient clinical records; outpatient clinic encounter and insurance disclosure forms; supplemental care payments; and patient, insurance, attorney, and work release requests for potential MAC cases

- Interview patients at point of entry regarding accident information (how, when, where). This includes outpatient care, pre-admission, and admissions interviews

Your Responsibilities to Comply as Outlined in the UBO Manual slide 2

- Promptly notify the RJA regarding treatment
- Provide claim forms with accurate cost computation
- Provide copies of supporting medical records, as requested by the RJA
- Provide copies of paid vouchers for patients treated in civilian facilities (supplemental care, etc.) as requested by the RJA

Your Responsibilities to Comply as Outlined in the UBO Manual slide 3

<u>MTFs shall establish internal controls</u> for cases sent to the RJA for recovery. These controls shall cover:

- Dispositions of claims
- Deposits of funds to the MTF's account
- Timely reporting of information about potential or ongoing affirmative claims
- Provisions of accurate cost computations for care provided through the MTF
- Copies of supporting medical records

MTFs must provide an updated fund cite for depositing funds at the start of each fiscal year

Other Elements of a Successful MAC Program

- Successful business relations with legal and medical staff
- Timely identification of possible MAC cases
- Organization
- Audit procedures
  - With legal staff
  - With medical staff
- Training medical staff on MAC

Successful Business Relations with Legal and Medical Staff

- **Memorandum of Understanding (MOU)**
  - Should address what is expected from MTF and Legal
  - Should outline timeframes for work to be completed
- **Flexibility**
  - Be flexible, the legal office may need certain items quickly with little or no notice
- **Prompt Customer Service**
  - Remember the Legal Office staff is your customer

Timely Identification of Possible MAC Cases

- **Injury Log**
  - AF Form 1488
  - Navy Form NAV JAG 5890/12 (REV. 3-78) (5890-1)
  - Army DA Form 2641-R

- **Other Methods to Identity Potential MAC Cases**
  - Inpatient screenings
  - Emergency room reports
  - Ambulance records
  - Request for medical records by third party (attorney or insurance company)

Organization

- Daily Checklist
- File System
- Weekly Checklist
- Monthly Checklist
- Other Organizational Tips

Audit Procedures

- You should meet with your RJA at least monthly to:
  - Reconcile open and closed MAC cases
  - Reconcile monthly and yearly amounts collected
- You should perform an audit to ensure all clinics are logging as many potential MAC cases as possible using the injury log. Perform an audit at least monthly, weekly if possible!
  - Use CHCS reports _____

Training Medical Staff on MAC

- You are responsible for insuring that all clinic personnel are properly trained regarding the identification of potential MAC cases.
- Set up a training plan to include:
  - Regularly scheduled training sessions at least quarterly to include providers, RN's, techs, records clerks and administrative staff
  - Initial training for all incoming personnel

Creating Bills

- There are a couple of billing methods currently available. They include but are not limited to:
  - TPOCS:
    - HCFA 1500
    - UB-92
  - Service specific forms:
    - AF Form 438
    - Navy Form NAV JAG 5890/12 (REV. 3-78) (5890-1)
    - Army DA Form 2631-R

Currently there is no official guidance as to which form(s) must be used.

Creating Bills
Identifying Correct Billable Rate

- Procedure code determines billable rates
- Rates published on Champus Maximum
- Allowable Rate table (CMAC)
- Rates accessible thru TPOCS and UBO web site

Creating Bills - HCFA 1500

- When to use the HCFA 1500
  - For Professional Fees
  - TPOCS will automatically select correct form
- How to create the HCFA 1500

Creating Bills - UB-92

- When to use the UB-92
  - For Instructional Fees
  - TPOCS will automatically select correct form
- How to create the UB-92

Posting Payments in TPOCS

- If you bill MAC encounters using the UB-92 or HCFA 1500, recommend posting all payments received via legal for services billed
- Use copy of deposit form to verify payment collected

Creating Bills Service Specific Forms

- AF Form 438
- Navy Form **NAV JAG 5890/12 (REV. 3-78) (5890-1)**
- Army DA Form 2641-R

Medical Affirmative Claims Self-Evaluation

- Complete the Medical Affirmative Claims Self-Evaluation Form
- Results

Let's Review

- The day in the life of a MAC technician
  - Daily requirements (check list)
  - Weekly requirements (check list)
  - Monthly requirements (check list)
- Tips and good practices to remember
- Additional handouts

Discussion

Medical Affirmative Claims
Check List

Daily	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Make rounds to all clinics and ER to collect previous days Injury Logs																															
Check with medical records staff to see if any open MAC records were returned from previous day.																															
Ensure all Injury logs collected are complete																															
Copy and file previous days Injury Logs																															
Forward all original Injury Logs to legal office																															
Review any MAC Records turned in from previous day. Create new bills if needed.																															
Copy and file new bills created																															
Forward new bills to legal office (originals)																															
Review Injury logs returned from legal																															
Create and potential or new MAC billings as requested from the returned injury log																															
File returned Injury Log with copy																															
Complete all request for medical records or other documentation from legal																															
Forward all requested information to legal																															
Return any medical records to the Records department																															

Medical Affirmative Claims
Check List

Weekly	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Review all open MAC Cases and bill for any additional treatment. Forward new bills to legal. Close any MAC cases where treatment is completed and forward final bill or notification of completed treatment to legal.																															
Meet with Medical Records Clerk to determine if any new requests for medical records via Attorney office has been made. Report findings if any to legal.																															
Audit clinics using CHCS reports to ensure they are logging all injuries on the Injury Log																															
Provide feed back to clinics NCOIC if needed																															
Contact legal rep to touch base. Double check that all of there requests have been meet timely.																															

Medical Affirmative Claims
Check List

Monthly	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Audit of open and closed MAC cases with legal office																															
Review your copies of out going Injury logs and notify legal of any that have not been returned timely. Provide another copy if needed.																															
Verification of Funds collected and deposited.																															

Medical Affirmative Claims
Check List

Quarterly or as needed
Provide training to all MTF clinics on proper use of Injury Log

Opening a new MAC Claim
Check list

Opening New MAC Case	
Review medical record and mark all visits that are MAC related (using MAC / TPL stamp)	
Copy any applicable medical record or other supporting documentation for legal.	
Flag medical record as an open MAC case (using MAC Index Card)	
Create billing for all medical treatment provided that is MAC related	
Enter new MAC case into MAC AR spreadsheet	
Copy bills and file. One copy in medical record. One copy in MAC Clerk FY binder	
Send original bills + 1 copy and supporting documentation to legal	
Review medical record for Other Health Insurance. Notify TPC staff if there is any OHI.	

Opening a new MAC Claim
Check list

Reviewing / Updating Open MAC Case	
Review medical record and mark all visits that are MAC related (using MAC / TPL Stamp)	
Copy any applicable medical record or other supporting documentation for legal.	
Flag medical record as an open MAC case (using MAC Index Card)	
Create billing for all medical treatment provided that is MAC related	
Enter new MAC case into MAC AR Spreadsheet	
Copy bills and file. One copy in medical record. One copy in MAC Clerk FY binder	
Send original bills + 1 copy and supporting documentation to legal	
Review medical record for Other Health Insurance. Notify TPC staff if there is any OHI.	

Opening a new MAC Claim
Check list

Closing MAC Case (treatment completed)	
Review medical record to ensure all billable encounters have been properly marked and billed. If yes and treatment is complete then proceed with closure.	
Notify legal of completed treatment.	
Remove MAC index card from exterior of record	
Annotate MAC case as treatment completed with date on MAC AR	
If case is determined by legal to not be collectable and there is OHI close or withdraw all claims billed and forward to TPC office for assertion against the Health Insurance Carrier.	

Medical Affirmative Claims
Self Evaluation Form

	Yes	No
Does your program have a current established MOU with base legal?		
Are your clinics using a standard Injury Log?		
Are you training the clinics on the proper use of the injury log?		
Do you have any auditing procedures to ensure the clinics are completing the Injury Log?		
Are you forwarding the Injury Logs to legal daily?		
Do you have procedures in place for how to open a potential MAC claim?		
Are you forwarding itemized bills to legal by the agreed upon date (no longer than 1 week from date of request)?		
Do you have procedures in place for how to convert a potential MAC claim into an open MAC claim?		
Are you forwarding copies of all supporting documentation to legal as requested in the agreed upon time (I.e. Medical records with in one week of		
Do you have procedures in place on how to monitor the patient's treatment once an open MAC claim has been established?		
Do you have set criteria to meet in order to close an open MAC claim?		

MAC MANUAL BILLING INSTRUCTIONS FOR TPOCS

Because the receipt of data is not automated in TPOCS 3.0, the following instructions are provided to guide users in generating manual claims.

1. Insurance Information

   1.1. Manually enter MAC insurance companies into the TPOCS into Site Insurance Companies table. Path: **Tools: Table Maintenance: Site Insurance Companies**.

      1.1.1. This can be done by selecting the **Add Ins. Co.** icon, or selecting **Data: Add Insurance Co.** on the tool bar. Each field highlighted in yellow is required.

   1.2. Enter a **DoD ID** that will allow easy identification of the insurance company.

      1.2.1. Select the **DMIS ID** from the from the drop-down selection list. All other fields are self-explanatory.

   1.3. Save data.

      1.3.1. Use the **Save** icon, or select **File: Save**

   1.4. Indicate which services should print on which form. Be sure the forms you require are associated with the type of bill that will be produced.

      1.4.1. Select the **Change Print Form** button located in the lower right of **Insurance Company Maintenance** screen.

   1.5. Save changes. *Note: It is important to save both the insurance screen and the print form.*

2. Patient Information

   2.1. For a new patient, once the appropriate insurance information is in the insurance table, the patient's information is required. This is accomplished by completing the information in the **Patients & Policies** screen.

      2.1.1. Select **Patients: Patients & Policies**.

      2.1.2. Enter the patient's FMP/SSN into the **ID** field. No punctuation or spaces are included in the patient's FMP/SSN when it is entered.

      2.1.3. Tab to the Name field. The alert: **Patient Not Found** will appear with the question, "**Would you like to add this person as a new patient?**" Select **Yes**.

         2.1.3.1. The next screen to appear is the **New Patient** screen, with the question, "**Is this a MAC patient?**" Select **Yes**.

      2.1.4. Fill in all the pertinent information about the patient under the **Patient** tab. All fields highlighted in yellow are required.

2.1.5. Select the **Policies** tab to complete the insurance information for the patient. The information required in the **Insurance Company ID** field is the same information that appears in the **DoD ID** field in the **Insurance Company Maintenance** screen.

2.1.6. The remaining required information is self-explanatory.

2.1.7. Link the patient to the policy in the **Links** tab.

2.1.8. Save data exiting the screen.

2.2. If you suspect that the patient already exists in the **Patients & Policies** table, type the patient's last name in the Name field at the top of the **Patients & Policies** field. Then select the **?** button. This will show a list of all the patients in the system with that last name. The patient's name can be selected from the list, if that patient has been previously entered.

3. Site/Clinic for MAC Claims (Optional)

3.1. If the MAC claims return address is different from the TPCP address and/or TPOCS will be used to accumulate data for MAC claims, then a separate site and site reporting code can be created for MAC claims. Once this is done, then appropriate MEPRS clinics can be added to the **Clinic Maintenance** table and associated with the MAC sites.

3.1.1. Create a MAC site.

3.1.1.1. Go to the **Site Maintenance** screen. Select **Tools: Table Maintenance: Sites**.

3.1.1.2. Insert a new record. **Data: Insert**. Enter the appropriate information.

3.1.1.3. Save the new site.

3.1.2. Create a MAC site reporting code.

3.1.2.1. Go the **Site Reporting Code Maintenance**. Select **Tools: Table Maintenance: Site Reporting Code**.

3.1.2.2. Insert a new record. Ensure the **Reporting Code** and **Reporting Code Description** correspond to the information in the **Site Maintenance** screen.

3.1.2.3. Save the new information.

3.1.3. Create a clinic associated with the MAC site and site reporting code.

3.1.3.1. Go to the **Clinic Maintenance** table. Select **Tools: Table Maintenance: Clinics**.

3.1.3.2. Enter, or copy from an existing clinic, the **Code** (MEPRS code) and **MEPRS/Clinic Description**. Be sure that the MAC site information is chosen from the pick lists for the **Reporting Code**, **Site ID**, **Billing Reporting Code**, and

Billing ID. A clinic can be entered more than once, as long as the entries are associated with different sites.

3.1.3.3. Save the new information.

3.1.4. Create a Customized CMS Form for the optional MAC reporting code.

3.1.4.1. Go to **Custom CMS.** Select **Tools: Table Maintenance: Custom CMS.**

3.1.4.2. Save information.

4. Creating a MAC Claim

4.1. Enter the appropriate clinical information in the MAC billing screen from the data gathered from CHCS (ADM, LAB, RAD, and PHR modules)

4.1.1. **Billing: Create Bill: MAC**.

4.2. Ensure that the:

4.2.1. Correct **Bill Type** is selected.

4.2.2. MAC **Reporting Code** is selected.

4.2.3. **Occurrence Code** and **Occurrence Dates** fields are completed.

4.3. Save the claim. *Note: In the **Select Bills** screen, MAC claims can be identified by the **Entry User** or by the **Source**.*

5. Printing a MAC Bill

5.1. This procedure does not differ from the normal printing procedures. If a separate **Reporting Code** has been created for MAC bills, ensure that the correct **Reporting Code** is selected.

6. Billable Services Obtained from CHCS

6.1. For manual billing, billable services can be identified in the various CHCS Subsystems. The user must have access to the CHCS subsystems listed below. *Note: Since these options are "View Only", minimal training is required.*

6.1.1. Patient Encounter Records Report. Path **ADM: Option 2 (Reports): Option 11 (Patient Encounter Records Report)**

6.1.2. Laboratory Inquiry. Path **LAB: LPI: PLI**

6.1.3. Radiology Inquiry. Path **RAD: EP: EI**

6.1.4. Pharmacy Inquiry. Path **LAB: LPI: RXI**

Billing Work Arounds: APV, Ancillary, & Pharmacy

APV

- Surgery schedules are obtained every Friday for the following week
- Patients with OHI are identified and pre-certification is obtained, if required.
  - Medical record documents are forwarded to insurance carrier

APV

- Admissions is checked every morning to determine if any overnight admissions require pre-certification
- Surgery schedule checked every afternoon for add-on patients

APV

- A copy of the pre-certification and the surgery schedule is maintained
  - Upon completion of coding, information is used to verify the data extract pushed over to TPOCS
  - If no data extract has occurred within 2-3 weeks, Inpatient Records is contacted for status update

Pharmacy

- A ad hoc report is executed from CHCS
  - The dispensed date signifies the report begin and end date
- The report is downloaded into Excel and column headings are added
- The report is used for billing
  - Bills are selected in TPOCS and matched to the ad hoc report
  - If there is a claim on the report but not in TPOCS, the claim is manually billed
  - If the claim is in TPOCS by not on the ad hoc report, CHCS is checked to verify if the prescription was dispensed

Pharmacy

- The ad hoc report can also be sorted by patients and then by date.
  - This ad hoc is used for back billing
- Pharmacy claims are printed on a UB-92
  - Diagnosis code is captured
  - Drug name / description is entered

Pharmacy

- 90 day supply is billed
  - Payers will pay the 30 day supply and deny the balance
- Exception is Well Point
  - When the 90 day claim is denied, the claim is reprinted and annotated with "30 day supply"
    - The quantity dispensed is changed
    - The days supply is changed
    - The amount billed is changed
  - The claim is stamped with "Corrected Claim" and resubmitted

Ancillary: Internal Providers

- When the clinics order lab/rad correctly, the order will link with an appointment and include a diagnosis code
- If the diagnosis code is not included, a manual match is performed with an appointment
- An ad hoc report is used for those orders which can not be matched
  - The report identifies patient name, date of service, MEPRS code, and physician
- The ad hoc is given to the Group Practice Manager with a deadline for ICD-9 code retrieval

Questions, thoughts, comments?

Reports and Reconciliation Procedures

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Objectives

- Understand System Reports
- Generate Reports that Validate Your Work
- Prepare Metrics that Accurately Depict Your Program
- Measure Your Compliance

Understanding System Reports

- Billing systems are designed to assist the user to accurately balance accounts, analyze results, and prepare comprehensive informational documentation.
- The Data Base Administrator (DBA) may be of help with ad hoc reports that are focused on a particular element of interest

CHCS System Reports

MSA

Select Core Application Drivers Menu Option: MSA MSA System Menu

- CFM Cashier Functions Menu (user entry port)
- OFM Office Functions Menu
- MSR Cashier/MSA Reports Menu
- C7A USCG DD7A Billing Menu
- D7A DD7A Billing Menu
- MRM Monthly Reports Menu
- NPM Nightly Processing Menu
- RSM Reprint Reports Menu
- FIM Inquire to File Entries
- LFA List File Attributes
- IFM Insurance Processing Menu
- OIB Outpatient Itemized Billing Menu

Select MSA System Menu Option: OFM Office Functions Menu

- AAS Schedule of Accounts by Age
- BCP Balance Check
- DAR Detail Schedule of Accounts by Age
- ERS Rate Schedule Enter/Edit
- FDF Fund Description Edit
- EXC Outpatient Charge Exclusion Enter/Edit
- GMS Group Meal Sales Enter/Edit
- MPF MSA Parameters Definition
- NMR Notify Messages Review/Clear
- PCE Patient Category Enlisted Billing Info
- RDS Rate Detail Summary
- RSS Rate Schedule Summary
- SRC Statement of Receivables and Collections
- VRS View Rate Schedule Detail

Select MSA System Menu Option: MSR Cashier/MSA Reports Menu

- 139 Produce DD139
- AAR Active Accounts Receivable Report
- CCR Cash Collection Detail Report
- CRA Clinical Records Pending DRG Billing Report
- FCV Final Cash Collection Voucher
- IRR Invoice and Receipt
- NRR Notify Roster
- PCT Patient Category Billing Table
- PTS Projected Transfer Summary
- RCC Copying Charges Roster
- REC DRG Billing Report of Current/Recalculated Charges
- SDS DRG-Eligible Indicated Same Day Surgery Report
- STM Consent Statement
- TWO Accts Subject to Transfer/Write-off
- VCL Voucher Control Listing
- WRT Accounts Written-Off

Select MSA System Menu Option: D7A DD7A Billing Menu

- PRE Preview Billing List
- MBP DD7A Monthly Outpatient Billing Process
- RPD Reprint DD7A

Select MSA System Menu Option: MRM Monthly Reports Menu

- 186 Accrual - - 1860R Detail
- CBR Central Billing/Local Collection
- D10 Enlisted 1080 Report Detail
- DD7 DD7 Report
- E10 Enlisted 1080 Report
- MMD Monthly Medical Services Activity Detail Report
- MMR Monthly Medical Services Activity Report
- O10 1080 Report

Select Core Application Drivers Menu Option: fim
Inquire to File Entries

Output from what file: cmac

CMAC

1 CMAC Provider Class (4 entries)

2 CMAC Rate (126085 entries)

Output from what file: dd7
DD7A Holding File

Output from what file: oib
OIB NDC Rate Table

Output from what file: itemized billing suspense file
Select ITEMIZED BILLING SUSPENSE
SERVICE DATE/TIME: ??

Select MSA System Menu Option: OIB Outpatient Itemized Billing Menu

- ECR Outpatient Charge Exclusion Report
- EXC OIB Exception Report
- IBP Outpatient Itemized Billing Preview List
- ONR MSA Outpatient Notify Roster
- RES Restart OIB Suspense File Processing for TPOCS
- VER OIB Insurance Verification Report

Medical Affirmative Claims (MAC)

There are currently no system reports that support the MAC Program

- Follow service guidance
- If TPOCS is used, some accountability reports are available
- CHCS system ad hoc reports can help identify potential claims

Inpatient Third Party Collection Reports

Select MSA System Menu Option: ifm Insurance Processing Menu

- IAP Insurance Account Processing
- OPM Output Products Menu
- QRP TPC Quarterly Output Products Menu
- IOR Insurance and OHI Report Menu
- CPT TPC Ancillary CPT Report (DoD Cost)
- TRI TPC Batch Post Closing of Transferred Accounts
- XDL Clear Delinquent Letter Print Queue
- CPQ Clear UB92 Print Queue
- 25R Identify UB92 for Reprint
- VAP APV Prior Authorization Menu

MSA-IFM-OPM

- AAR – TPC Accounts Receivable Report
- BIL – Form UB92 (and delinquent packages)
- CRA – Clinical records Pending DRG Billing Report
- CSD – Insurance Claim Summary by Date Range
- DLP – Print Delinquent Letters
- IOP – TPC Negative Balance
- LOG – Insurance Payment Log
- MMR –TPC Monthly Activity Report

Cont >

Cont.

- NOT – Insurance Notify Roster
- OFF – TPC Write-Off Report
- PCT – Patient Category Billing Table
- QRS – Print Queue/Preview Roster
- REC – TPC MMSA Reconciliation Report
- TRF – Outstanding Insurance Transfer List
- UNK – Report of Policies with Unknown Companies
- URR – Insurance Precert/UR Roster
- WRK – TPC Insurance Worksheet

Select Insurance Processing Menu Option: IOR Insurance and OHI Report Menu

- EIC Insurance Company Edit
- VIC View Insurance Company Data
- TMP Temporary Insurance Company Enter/Edit
- ATT Attorney Enter/Edit
- REP Report of Standard Insurance Companies
- TSI TPOCS Insurance Company ASCII File
- ICA CHCS Insurance Company ASCII File
- RTE Insurance Reasons Table Enter/Edit
- OHI Other Health Insurance Report

Select MSA System Menu Option: QRP TPC Quarterly Output Products Menu

- DSA DRG Billing Analysis ASCII Format
- DSL DRG Billing Analysis Report
- EPR TPC Report of Program Results Detail
- GSC TPC Aging Schedule Report
- HAG TPC Aging Schedule Detail Report
- PRR TPC Report of Program Results
- SAR TPC Collection Source Analysis
- TYR TPC Insurance Report

Outpatient Third Party Collection Reports

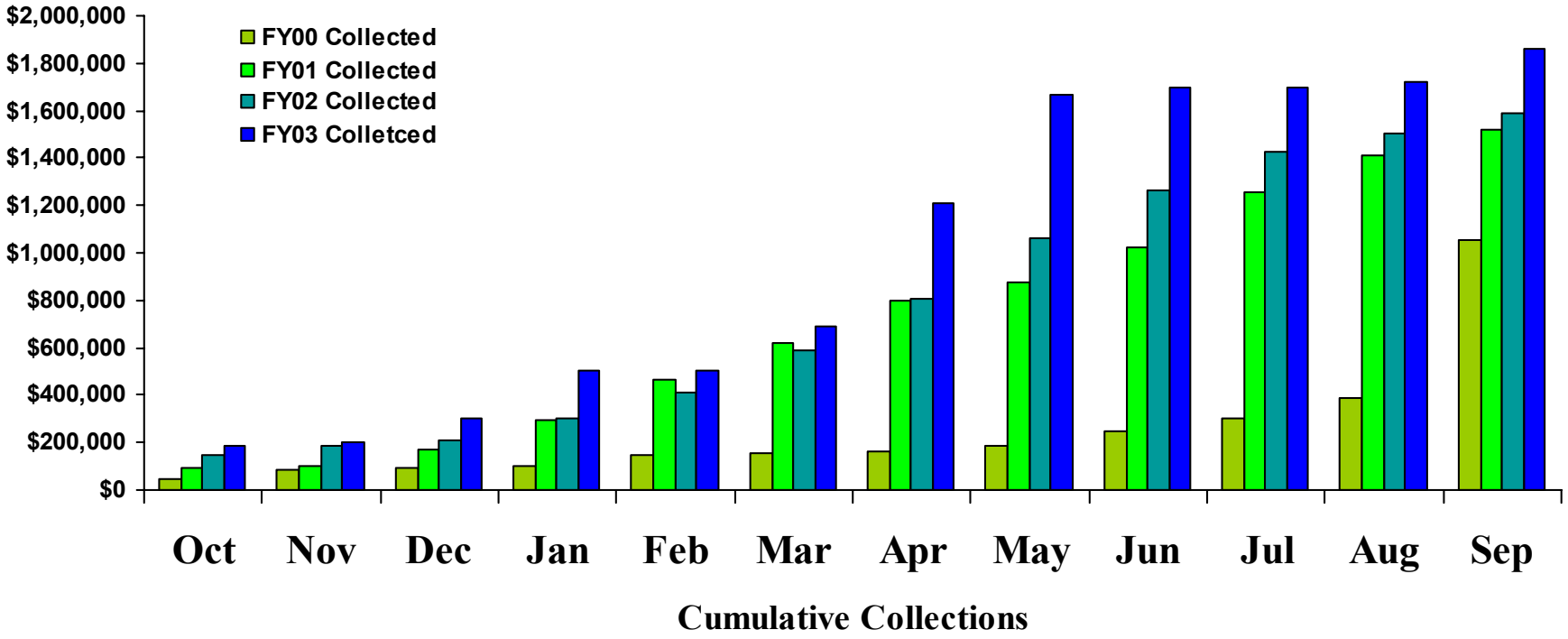
- Balancing in TPOCS is done with several different reports depending what you are doing
- TPOCS reports are self explanatory and you can select the needed reconciliation report form the reports menu
- Questions regarding TPOCS should be directed to the helpdesk Problemreport@tpocshelpdesk.com or 1-866-774-8762

Generate Reports that Validate Your Work

The systems provide information to help you prepare metrics that accurately depict your program

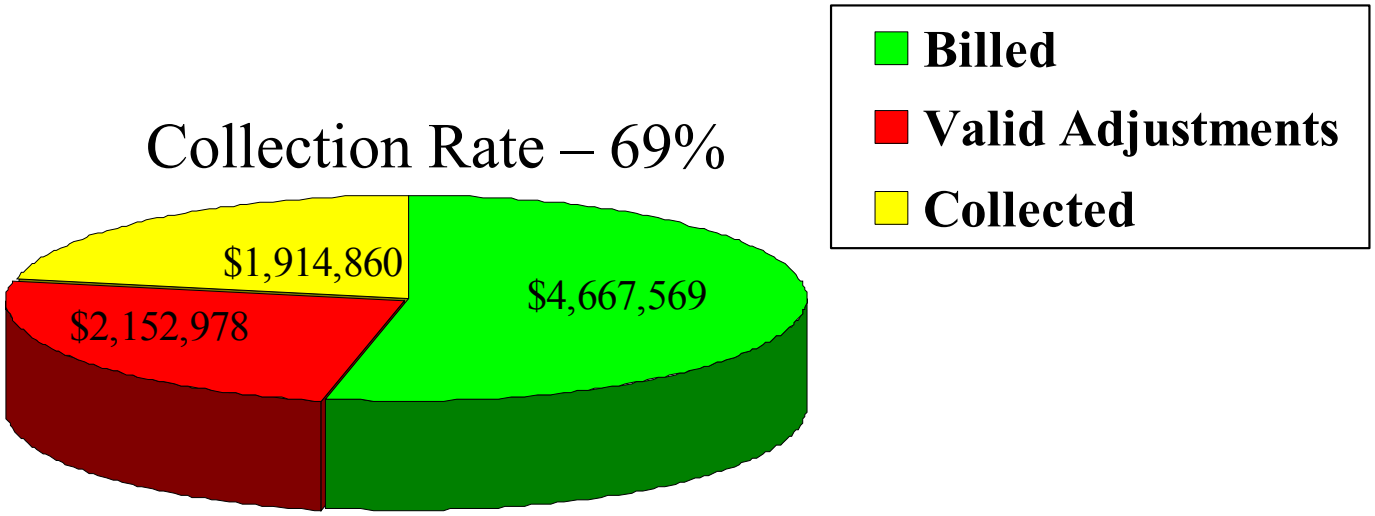
- Web based Metrics (DD Form 2570)
- PowerPoint Graphs
- Excel Spreadsheets

Inpatient TPC Collections



Source – CHCS Payment Log Report

Collection Rate (Outpatient and Ancillary)



(Billed – Valid Denials / Collected = Collection Rate)

Source – FY01 4th Qtr , DD Form 2570 (cumulative billed, adjusted and collected)

Measure Your Compliance

Reporting and Compliance go hand-in-hand

- The compliance program should effectively articulate and demonstrate the organization's commitment to legal and ethical conduct
- Promote prevention, detection and resolution of conduct that does not conform to Federal and State law, and Federal, State and private payor health care program requirements, as well as the billing company's ethical and business policies.
- A compliance program should become part of the fabric of routine billing operations

http://www.tricare.osd.mil/ebc/rm_home/files/ubo/ubo_8.htm

The compliance checklist is available on the web, use it.

- http://www.tricare.osd.mil/ebc/rm_home/files/ubo/ubo_compliance_audit_checklist_template_updated022602.doc

Questions?

TMA UBO

Cost Recovery Program Desk Level Reference

TPC – MAC - MSA

Purpose

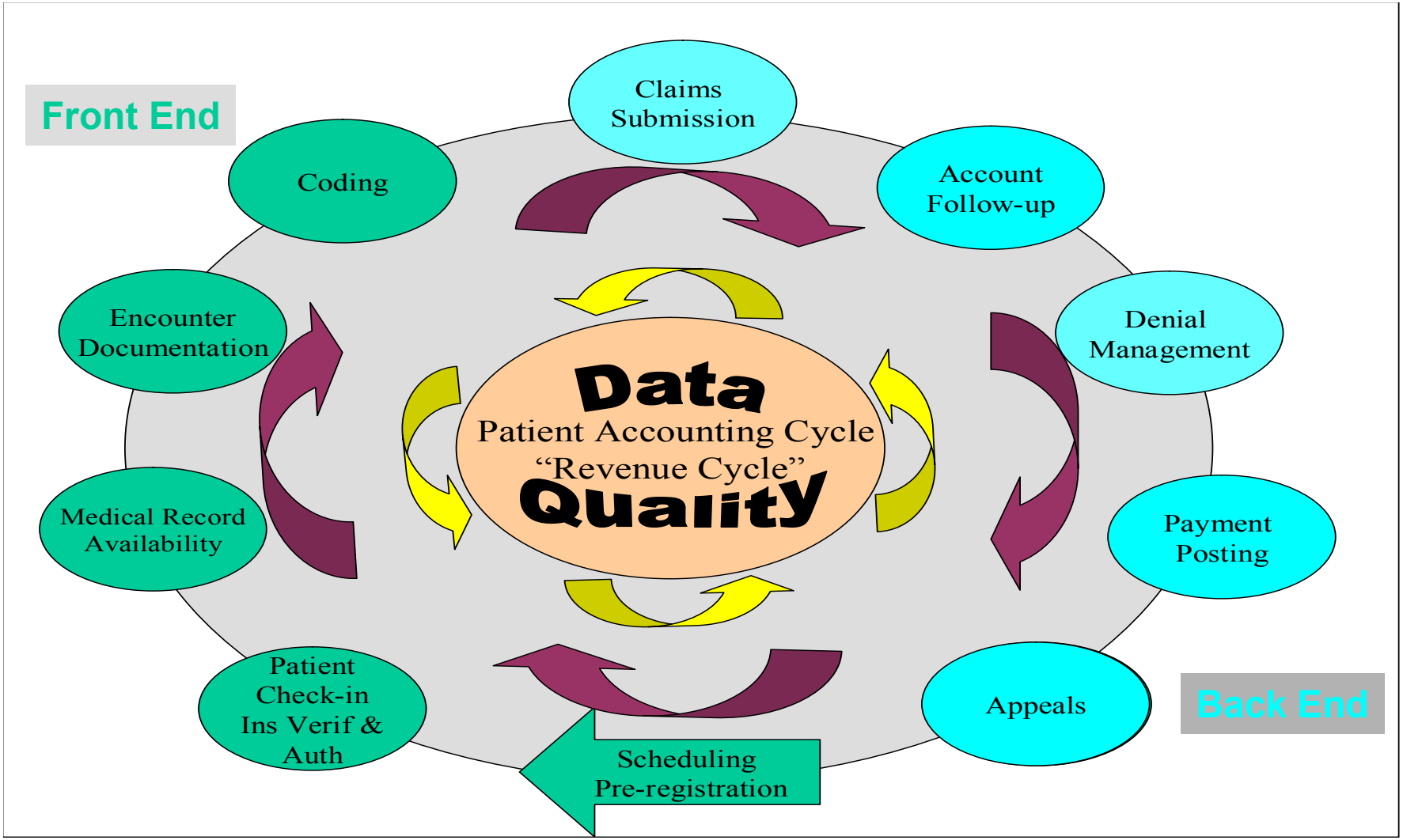
This Desk Level Reference is designed to provide you with essential information to optimize reimbursement, bring clarity to the billing process, and serve as a handy resource for all billable events covering TPC, MAC, and MSA.

What is The Desk Level Reference?

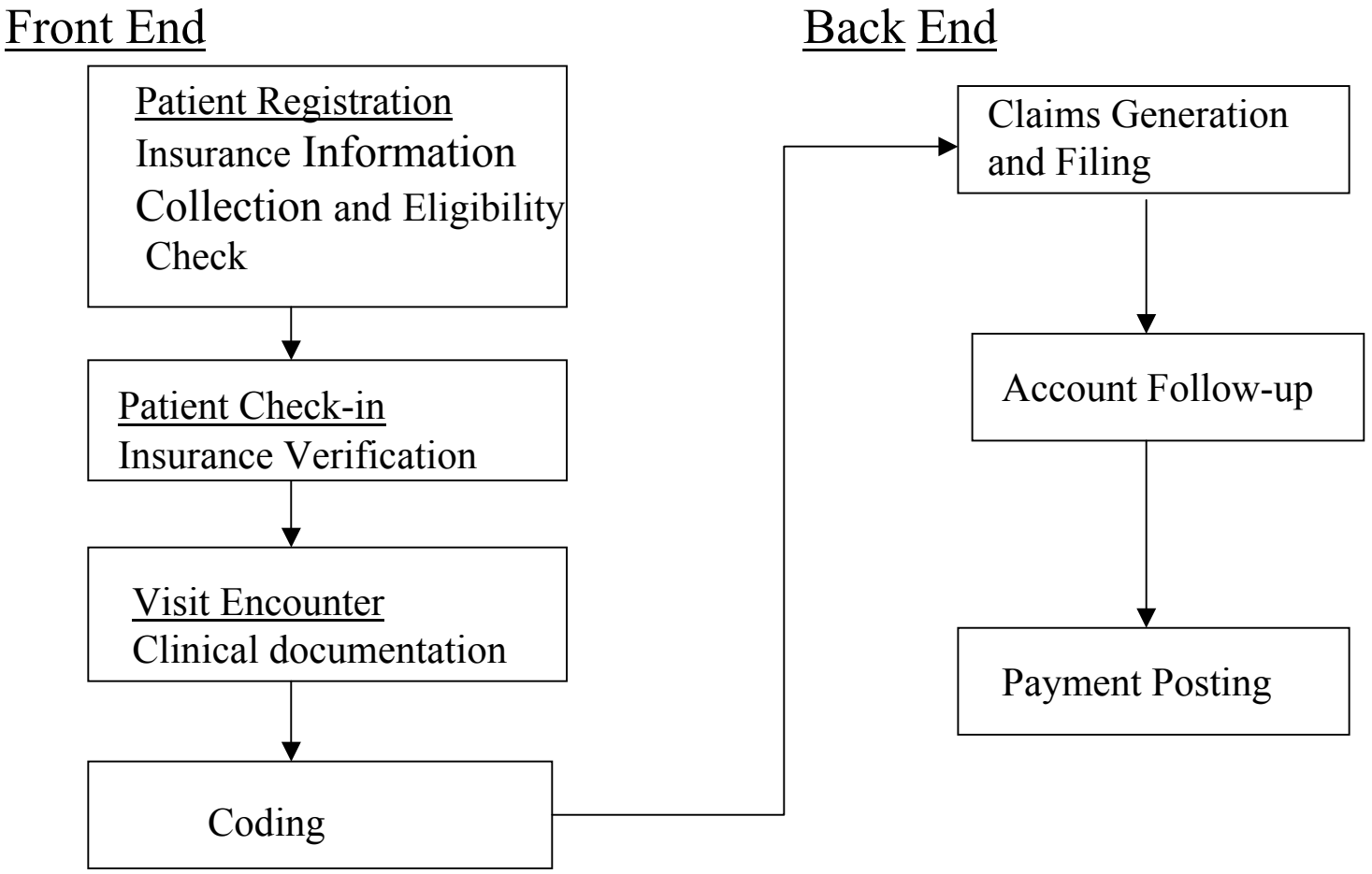
- Each page has a Main Topic
- Each Main Topic will address the essential aspects of the Cost Recovery Program (TPC, MAC, and MSA)
- These essential aspects should be the same for Army, Navy, and Air Force
- Contact the UBO Hotline for assistance at:

  (703) 575-5385 or UBO.Helpdesk@altarum.org

MTF Revenue Cycle Management



Revenue Cycle: A Brief Review



Revenue Cycle

Interdependency among all MTF Staff is paramount in optimizing reimbursement

Front End

- **Scheduling**
  Patient Access
- **Verification**
  Insurance Confirmation
- **Patient Care**
  Health Information Management
- **Disposition**
  Health Information Management
- **Coding**
  Health Information Management

Back End TPC – MAC - MSA

- **Billing**
  Billing/Collections
- **Itemized Billing**
  Billing/Collections
- **Close Account**
  Billing/Collections

Clean Claims

are the responsibility of all MTF personnel

- Back End
  - Electronic submission of claims
  - Correct claim forms for care rendered, services provided, and OHI validation
  - Decrease claims follow-up time
  - Decrease denied and partially paid claims
  - Claims free of impropriety and circumstance that require special attention
- MTFs contribute to clean claims and optimize reimbursement by:
  - Collecting OHI at time of appointment scheduled or POS
  - Submitting timely and accurate documentation
  - Coding accurately to the highest level of specificity
  - Billing timely and accurately

Other Health Insurance (OHI)

- CHCS is the source system for all patient OHI information
- TPOCS no longer supports OHI entry
- Accurate OHI capturing is *essential* for Third Party Billing and optimizing revenue
- Use open-ended questions when asking patients for OHI
  ["Where are you employed?" "Have you updated your OHI this year?"]
- Copy the front & back side of the insurance card and file in medical record
- Patient must complete, date and sign form DD2569
  [Copy to TPC Manager and original in Chart]
- Verify insurance benefits with third party payer
  [Enter into CHCS within 3 days of visit]
- Confirm patient's OHI at every appointment and review at least annually

Standardized Insurance Table (SIT)

- CHCS is the source system for SIT information
- TPOCS no longer do manual entry of SIT
- TPOCS will receive daily transmission of all SIT data, , including CHCS updates
- SIT updated quarterly
- TPC Manager enters temporary SIT entry; once the new temporary entry record is filed, the record cannot be edited
- All new SIT add requests go to Theresa.Boyd@altarum.org for verification

  [Use the SIT Add Request form located on the UBO website at http://tricare.osd.mil/rm/ubo_sit.cfm

MSA Tips & Key Points

- Remember to batch print your reports daily
- Remember to verify accounts within 14 days
- DD7A can be printed itemized (detailed) at your discretion
- You have the ability to append or exclude charges

MSA Menu

- CFM – Cashier Function Menu
  - OPE – Outpatient Accounts Edit
  - CLK Cashier Actions Edit
- OFM – Office Functions Menu
- MSR – Cashier/MSA Reports
- D7A – DD7A Billing Menu
- MRM – Monthly Reports Menu
- NPM – Nightly Processing Menu
- RSM – Reprint Reports Menu
- OIB – Outpatient Itemized Billing

Outpatient Itemized Billing (OIB) Menu Options

- ECR – Outpatient Charge Exclusion Report
- EXC – OIB Suspense File Exception Report
- IBP – OIB Preview Link
- ONR – MSA Outpatient Notify Roster
- ONR – MSARES – Restart OIB Suspense File Processing for TPOCS
- VER – OIB Insurance Verification Report

Compliancy

- Compliance is the act or process of conformity in fulfilling the official requirements such as laws, rules, and regulations that govern Medicare, Medicaid, and other third party billing.

- Non-Compliancy should be reported immediately to the MTF Compliancy Board or POC. This can be an anonymous telephone call.

- Become familiar with your MTF Compliancy Plan and how it is enforced, monitored and communicated to all MTF staff.

+ Compliancy -

Benefits of Being Compliant

- Ensures there are no patterns of wrong doing
- Reduces fraud and abuse
- Improves medical documentation
- Improves collaboration, communication and cooperation among healthcare providers and staff

Risks When Not Compliant

- Endangers the mission of the MTF or billing operations
- Harms the reputation and legal status of billing operations
- Possible loss of medical facility accreditation
- Possible loss of license to practice
- Civil monetary penalties
- Adverse professional action

System Default Claim Forms

The TPOCS extracts received from CHCS/ADM automatically splits charges into UB-92, UCF and CMS-1500 claim forms

The code range will generate the appropriate claim form

- 99201-99499, E/M Codes – CMS-1500
- 70010-79999, Radiology Codes (26) – CMS-1500
- 70010-79999, Radiology Codes (TC) – UB-92
- 80048-89399, Path & Lab Codes – UB-92
- NDC#, Pharmacy Revenue Code – UCF or UB-92
- Obs., Amb., Imm. And DME/DMS Codes – UB-92
- ADA/CDT Dental Codes – ADA

Supporting Documentation

"If it is not documented in the medical record, it was not done"

- Documentation must be complete and legible
- Documentation should be completed at time of care rendered/service provided
- Documentation assure continuity of care, past and present medical conditions, anywhere, anytime, by any provider
- Eliminates the possibilities of overlooking aspects of patient's care
- Very critical for correct billing and reimbursement
- It is everyone's responsibility…..remember the Revenue Cycle!

Example: Payers Payors may require supporting documentation when submitting claims for specific modifiers (22,53) and procedures (cosmetic surgery).

E/M Levels

- Multiple E/M codes (up to three) can be captured with the use of modifiers
- Without modifiers, only one E/M can be associated with an encounter
- New Patient – – a patient that presents for the first time or for the first time in 3 years
- Established Patient – a patient that has been seen within 3 years and has received services from a privileged provider
- Elements of E/M Levels – Place of Service, Type of Service, and Status of Medical Visit
- 7 Components of E/M –
  - Key Components
    - History – Physical Examination – Medical Decision Making
  - Contributory Components
    - Nature of Presenting Illness – Counseling – Coordination of Care - Time

Hold Periods

TPC

- **OHI Hold** – hold period is based **3 Day** on 3 days from the date of service for all ADM, Lab, Rad, and Pharmacy data

  Data transmitted from CHCS/ADM to TPOCS
- **ADM/LAB-RAD 7 Day Hold** – hold period is based on 7 days from date of service.

  Data transmitted from CHCS/ADM to TPOCS on a daily basis
- **Pharmacy 14 Day Hold** – hold period is based on 14 days from the date of service.

  Data transmitted from CHCS/ADM to TPOCS on a daily basis

MSA

- **OHI 3 Day Hold** - hold period is based on 3 days from the date of service for all ADM, Lab, Rad, and Pharmacy data
- **ADM/LAB-RAD and Pharmacy 14 Day Hold** - hold period is based on 14 days from the date of service.

Reasons for Hold Periods

- Reduces the number of claims submitted to payers
- Allows time for the encounter information to link with ancillary or pharmacy information

Rate Tables

- **CMAC** – this rate table has majority of the codes. It is organized It is organized by 90 localities which correspond to DMIS ID codes. .
- **Component** – this table contains the rates for codes which are broken down into professional (modifier 26) and technical (modifier TC) components. .
- **Non-CMAC** – this table contains the rates for the procedures which are normally priced on a statewide basis (prevailing fees).
- **Anesthesia** – charges based on CPT-4 Codes (00100-01999). There is a flat rate for this range of codes.
- **DME/DMS** – charges based on HCPCS Level II "A,E,K,L, and V" codes.
- **Pharmacy** – prescription costs are based on National Drug Code (NDC) and Order Quantity. Quantity.
- **Dental** – charges based on CDT codes D0110-D9440. Gathering of data has not changed.
- **Immunizations/Injections** – charges are based on HCPCS Level II "J" codes and CPT- 4 Codes 90476-90799. .
- **Ambulance** –charges are based on default HCPCS Level II code A0999 in 15 minute increments. .

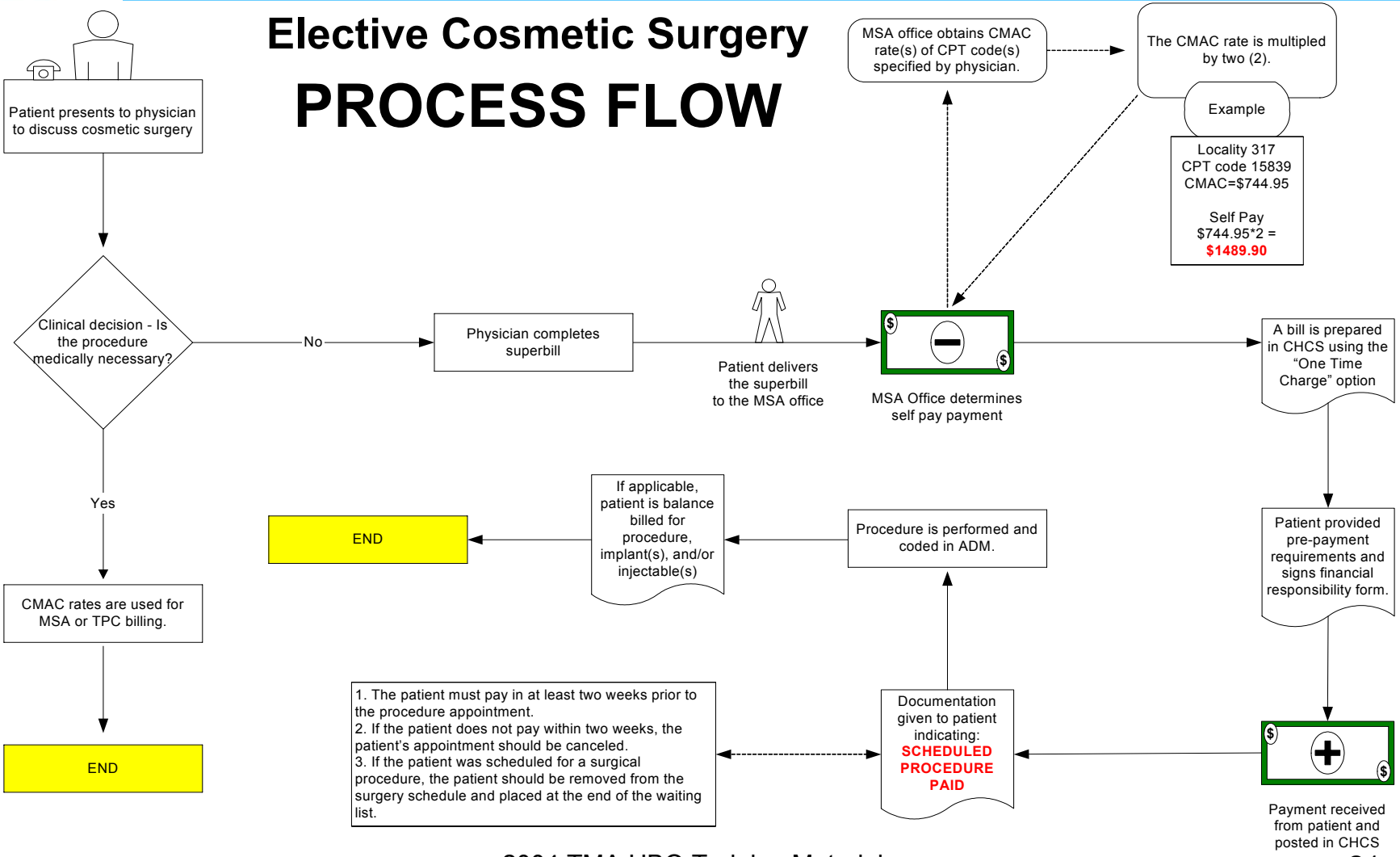
Elective Cosmetic Surgery

FIRST PARTY BILLING FLAT RATE DEVELOPMENT

- What does the flat rate **include**?
  - Pre- and routine post-operative visits
  - Elective cosmetic surgery procedure
  - Ancillary testing
  - Anesthesia
  - APV facility fee
- What does the flat rate **exclude**?
  - Implant(s)
  - Injectable(s)

    **Active duty service members are not billed for implant(s) or injectables(s)

Elective Cosmetic Surgery
PROCESS FLOW



Modifiers

Modifiers are two-digit adjectives, additional information that is not part of the CPT-4/HCPCS code description

- Modifiers can be
  - numeric
  - alpha-numeric
  - alpha

- Modifiers are used to
  - Impact reimbursement
  - Reduce audit exposure
  - Maintain coding and compliance
  - Present a clearer picture of care rendered/service provider
    - Modifier 26 – Professional Component>CMS 1500
    - Modifier TC – Technical Component > UB 92

Billing Tips for Use of Modifiers

- Biller may see duplicate CPT-4 codes listed on a claim form
  - Each code must have a different modifier or may be considered duplicate charges
- Multiple modifiers are available per CPT
- Some modifiers substantiate care only
- Some modifiers effect reimbursement
- Have a current Coding/CPT Book in your Billing Office as a reference
- Have questions? Contact:
  - UBO Hotline at (703) 575-5385or
  - http://tricare.osd.mil/rm/ubo_home.cfm

A positive working relationship between the billing office and the coders in your MTF will minimize rejected and/or denied claims and facilitate optimal reimbursement

2004 UBO Pilot Training

"Strengthening the Back End Processes"

- **Military Treatment Facility Uniform Business Office (UBO) Manual, DoD 6010.15-M**
  www.dtic.mil/whs/directive/corres/html/601015m.htm
- **Uniform Business Office (UBO) Business Rules**
  www://tricare.osd.mil/rm/ubo_policy_and_guidance.cfm
- **UBO Web Site**
  www://tricare.osd.mil/rm/ubo_home.cfm
- **UBO Help Desk**
  (703) 575-5385

- **MHS Help Desk** [TPOCS & CHCS]
  (800) 600-9332
- **Field Services website**
  https://fieldservices.saic.com
- **TPOCS Help Desk**
  http://tpocshelpdesk.com
- **RITPO [TPOCS] website**
  http://ritpo.ha.osd.mil/main_asp?a=1
- **CITPO [CHCS] website**
  http://citpo.ha.osd.mil/index.html

- **UBO Service Manager Contact Information**

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Glossary and Definitions

The following information has been excerpted from the "Department Of Defense Glossary Of Healthcare Terminology" (DoD 6015.1-M).

ABUSE. A pattern of improper or excessive use or treatment.

ADA. American Dental Association.

ADDITIONAL DIAGNOSIS. Any diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the physician considers of sufficient significance to warrant inclusion for investigative medical studies.

ADMISSION. The act of placing an individual under treatment or observation in a medical center or hospital. The day of admission is the day when the medical center or hospital makes a formal acceptance (assignment of a register number) of the patient who is to be provided with room, board and continuous nursing service in an area of the hospital where patients normally stay at least overnight. When reporting admission data always exclude: total absent-sick patients, carded-for-record only (CRO) cases and transient patients.

ADMITTING DIAGNOSIS. The immediate condition that caused the patient's admission to the MTF for the current, uninterrupted period of hospitalization.

ADM. Ambulatory Data System.

ANCILLARY. Tests and procedures ordered by healthcare providers to assist in patient diagnosis or treatment (radiology, laboratory, pathology, etc.).

APV. Ambulatory Patient Visit. Refers to immediate (day of procedure), pre-procedure and immediate post-procedure care in an ambulatory setting. Care is required in the facility for less than 24 hours.

ASSIGNMENT OF BENEFITS. The payment of medical benefits directly to a provider of care rather than to a member. Generally requires either a contract between the health plan and the provider or a written release from the subscriber to the provider allowing the provider to bill the health plan.

ATTENDING PHYSICIAN. The physician with defined clinical privileges that has the primary responsibility for diagnosis and treatment of the patient. A physician with privileges to practice the specialty independently. The physician may have either primary or consulting responsibilities depending on the case. There will always be only one primary physician; however, under very extraordinary circumstances, because of the presence of complex, serious and multiple, but related, medical conditions, a patient may have more than one attending physician providing treatment at the same time.

BALANCE BILLING. The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copays, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).

BPR. Business Process Reengineering. MHS Business Process Reengineering is a radical improvement approach that critically rethinks and redesigns product and service processes within a political environment to achieve dramatic MHS mission performance gains.

BUNDLING. Combining into one payment the charges for various medical services rendered during one health care encounter. Bundling often combines the payment from physician and hospital services into one reimbursement. Also called "package pricing."

CFR. Code of Federal Regulations.

CHCS. Composite Health Care System. Medical AIS that provides patient facility data management and communications capabilities. Specific areas supported include MTF health care (administration and care delivery), patient care process (integrates support--data collections and one-time entry at source), ad hoc reporting, patient registration, admission, disposition, and transfer, inpatient activity documentation, outpatient administrative data, appointment scheduling and coordination (clinics, providers, nurses and patients), laboratory orders (verifies and processes), drug and lab test interaction, quality control and test reports, radiology orders (verifies and processes), radiology test result identification, medication order processing (inpatient and outpatient), medicine inventory, inpatient diet orders, patient nutritional status data, clinical dietetics administration, nursing, order-entry, eligibility verification, provider registration and the Managed Care Program.

CHCS II. Composite Health Care System II

CHANGE MANAGEMENT. It is the process of facilitating change to current business operations and the assessment of an organization's readiness and acceptance towards the transition.

CLAIM. Any request for payment for services rendered related to care and treatment of a disease or injury that is received from a beneficiary, a beneficiary's representative, or an in-system or out-of-system provider by a CHAMPUS FI/Contractor on any CHAMPUS-approved claim form or approved electronic media. Types of claims and/or data records include Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug, Dental and Program for the Handicapped.

CLAIM REIMBURSEMENT. The payment of the expenses actually incurred as a result of an accident or sickness, but not to exceed any amount specified in the policy.

"CLEAN" CLAIM. A claim that is free of defect and impropriety, containing required substantiating documentation and also free of circumstances that require special treatment which may prevent timely payment.

CLINIC SERVICE. A functional division of a department of a Military Treatment Facility identified by a three-digit MEPRS code.

CMAC. CHAMPUS Maximum Allowable Charge

CMAC RATE TABLE. The rate table determines the payment for individual professional services and procedures identified by Current Procedural Terminology

(CPT) and Healthcare Common Procedure Coding System (HCPCS) codes which are used for inpatient and outpatient services.

CMS. Centers for Medicare and Medicaid Services formerly known as Health Care Financing Administration (HCFA).

CMS-1450/UB-92. The common claim form used by hospitals to bill for services rendered. Some managed care plans demand greater detail than is available on the UB-92, requiring the hospitals to send additional itemized bills. The UB-92 replaced the UB-82 in 1993.

CMS-1500. A claim form (Health Care Financing Administration) used by professionals to bill for services. Required by Medicare and generally used by private insurance companies and managed care plans.

COMPLIANCE. Accurately following the laws, rules and regulations that govern Medicare, Medicaid and other third party billing.

COMPONENT RATE TABLE. It is based on components that are comprised of professional, technical and global reimbursement rates.

CONSULTATION. A deliberation with a specialist concerning the diagnosis or treatment of a patient. To qualify as a consultation (for statistical measure) a written report to the requesting health care professional is required.

CONUS. Continental United States. United States territory, including the adjacent territorial waters located within the North American continent between Canada and Mexico. Alaska and Hawaii are not part of the CONUS.

COVERED SERVICE. This term refers to all of the medical services the enrollee may receive at no additional charge or with incidental copayments under the terms of the prepaid health care contract.

CPT. Current Procedural Terminology. A systematic listing and coding of procedures and services performed by a physician. Each procedure or service is identified with a five-digit code that simplifies the reporting of services.

CPT MODIFIER. A modifier is an addendum to procedure codes which indicates that a procedure has been altered by some specific circumstance but not changed in its definition.

DD7A. An outpatient treatment billing form used to report treatment rendered to pay patients. This billing form will include all billed charges for encounter-related procedures, services and/or billable standalone ancillary services.

DIAGNOSIS. A word used to identify a disease or problem from which an individual patient suffers or a condition for which the patient needs, seeks, or receives health care.

DMD. Doctor of Medical Dentistry

DME. Durable Medical Equipment. Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. An area of increasing expense, particularly in conjunction with case management.

DMIS ID. Defense Medical Information System Identification Code. The Defense Medical Information System identification code for fixed medical and dental treatment facilities for the Tri-Services, the U.S. Coast Guard, and USTFs. In addition, DMIS IDs are given for non-catchment areas, administrative units such as the Surgeon General's Office of each of the Tri-Services, and other miscellaneous entities.

DRG. Diagnosis Related Group. A grouping of Medicare inpatients used to determine the payment the hospital will receive for the admission of that type of patient. The group definition is based on diagnoses, procedures, presence of comorbidity/complication (CCs), age sex and discharge disposition.

E/M. Evaluation/Management

ELECTIVE CARE. Medical, surgical, or dental care that, in the opinion of professional authority, could be performed at another time or place without jeopardizing the patient's life, limb, health, or well being. Examples are surgery for cosmetic purposes, vitamins without a therapeutic basis, sterilization procedures, elective abortions, procedures for dental prosthesis, prosthetic appliances and so on.

EMERGENCY. Situation that requires immediate intervention to prevent the loss of life, limb, sight or body tissue or to prevent undue suffering.

ENCOUNTER. A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment.

EOB. Explanation of Benefits. A statement provided by the health benefits administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and net amount paid.

FAMILY MEMBER PREFIX (FMP). A two-digit number used to identify a sponsor or prime beneficiary or the relationship of the patient to the sponsor.

FORM LOCATOR (FL). There are 86 Form Locators on the CMS-1450/UB-92 Claim Form that are divided into four different categories. Each form locator represents a field on the UB-92 Claim Form where valid information is placed when submitting bills for reimbursement from the payers.

FY. Fiscal Year.

FRAUD. An intentional misrepresentation of the facts to deceive or mislead another.

GME. Graduate Medical Education. Full-time, structured medically related training, accredited by a national body (e.g., the Accreditation Council for Graduate Medical Education) approved by the commissioner of education and obtained after receipt of the appropriate doctoral degree.

HCPCS. Health Care Financing Administration's Common Procedural Coding System. A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes, but also has codes for services not included in CPT, such as ambulance. While HCPCS is nationally defined, there is provision for local use of certain codes.

HEALTH CARE PROVIDER. A healthcare professional who provides health services to patients; examples include a physician, dentist, nurse, or allied health professional.

HOLD PERIOD. The Outpatient Itemized Billing System hold periods represent different timeframes patient encounter data are held in the source system before the claims are sent to TPOCS to be processed. The hold periods are: OHI 3-day hold, Laboratory and Radiology 7-day hold, Pharmacy 14-day hold and MSA 14-day hold.

ICD-9-CM. International Classification of Diseases, 9th Revision, Clinical Modification. A coding system for classifying diseases and operations to facilitate collection of uniform and comparable health information.

IMMUNIZATION. Protection of susceptible individuals from communicable diseases by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin.

IMMUNIZATION PROCEDURE. The process of injecting a single dose of an immunizing substance. For a detailed discussion on counting immunization procedures, see DoD 6010.13-M (reference (a).

I&R. Invoice and Receipt. The I&R is a billing form used by MSA for inpatient hospitalization and to bill civilian emergencies for outpatient treatment. The I&R includes all billed charges for encounter related procedures, services and/or billable standalone ancillary services.

MAC. Medical Affirmative Claims. The Medical Affirmative Claims Program provide the statutory and regulatory authority to recover the reasonable value of medical care rendered for injuries or illness provided at the expense of the government to active duty members, dependents and retirees under circumstances creating third party tort liability.
MEPRS. Medical Expense and Performance Reporting System. A uniform reporting methodology designed to provide consistent principles, standards, policies, definitions and requirements for accounting and reporting of expense, manpower, and performance data by DoD fixed military medical and dental treatment facilities. Within these specific objectives, the MEPRS also provides, in detail, uniform performance indicators, common expense classification by work centers, uniform reporting of personnel utilization data by work centers, and a cost assignment methodology. (The two-digit MEPRS code identifies departments and the three-digit MEPRS code identifies clinic services.)

MSA. Medical Services Account. The MSA function involves billing and collecting funds from DoD beneficiaries, others authorized treatment in MTFs and civilian emergency patients for subsistence or medical services.

MTF. Military Treatment Facility. A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

NCPDP. National Council of Prescription Drug Program.

NON-CMAC RATE TABLE. This table captures pricing for procedure codes at the local or State levels. Each State/locality does not have the same set of prevailing fees. There is a difference in the HCPCS/CPT codes with prevailing fees for each locality.

OCCASION OF SERVICE. A specific identifiable act or service involved in the medical care of a patient that does not require the assessment of the patient's condition nor the exercising of independent judgment as to the patient's care, such as a technician drawing blood, taking an x-ray, administering an immunization, issuance of medical supplies and equipment; i.e., colostomy bags, hearing aid batteries, wheel chairs or hemodialysis supplies, applying or removing a cast and issuing orthotics. Pharmacy, pathology, radiology and special procedures services are also occasion of service and not counted as visits.

OCONUS. Outside the Continental United States.

OHI. Other Health Insurance.

OUTPATIENT. An individual receiving health care services for an actual or potential disease, injury or life style related problem that does not require admission to a medical treatment facility for inpatient care.

OUTPATIENT SERVICE. Care center providing treatment to patients who do not require admission as inpatients.

PATIENT. A sick, injured, wounded, or other person requiring medical or dental care or treatment.

PCM. Primary Care Manager. An individual (military or civilian) primary care provider, a group of providers, or an institution (clinic, hospital, or other site) who or which is responsible for assessing the health needs of a patient, and scheduling the patient for appropriate appointments (example: pediatric, family practice, ob-gyn) with a primary health care provider within the local MHS network.

PCP. Primary Care Physician. Generally applies to internists, pediatricians, family physicians and general practitioners and occasionally to obstetrician/gynecologists.

PRINCIPAL DIAGNOSIS. The condition established after study to be chiefly responsible for the patient's admission. This should be coded as the first diagnosis in the completed record.

PRINCIPAL PROCEDURE. The procedure that was therapeutic rather than diagnostic most related to the principal diagnosis or necessary to take care of a complication. This should be coded as the first procedure in the completed record.

PRIVILEGED PROVIDER. Privileged providers use E/M codes. He/she is essentially an independent practitioner who is granted permission to provide medical, dental and other patient care in the granting facility within defined limits based on the individual's education, professional license, experience, competence, ability, health and judgement. The provider had his/her qualifications reviewed by the credentialing review board, a scope of practice defined and a request for privileges approved by the privileging authority.

PROFESSIONAL COMPONENT. Professional services that have a professional component in which the physician reads and interprets the result of a test performed by a technician. The service will be designated with the use of a CPT-4 code and modifier – 26 on the CMS-1500 Claim Form.

PROFESSIONAL SERVICES. Any service or care rendered to an individual to include an office visit, X-ray, laboratory services, physical or occupational therapy, medical transportation, etc. Also any procedure or service that is definable as an authorized procedure from the CPT-4 coding system or the OCHAMPUS manuals.

PROVIDER. Healthcare professional or facility or group of healthcare professionals or facilities that provide healthcare services to patients.

RATE. Regular fee charged to all persons of the same patient category for the same service or care.

REFERRAL. Practice of sending a patient to another program or practitioner for services or advice that the referring source is not prepared or qualified to provide.

REVENUE CODE. It represents a specific accommodation, ancillary service or billing calculation and it is used on the UB-92 Claim Form. Revenue codes affect reimbursement, particularly for outpatient claims.

REVENUE CYCLE. It represents the beginning phase from the time a patient schedules an appointment for a clinic visit, to the end phase when the patient's account is closed after the MTF receives reimbursement.

TECHNICAL COMPONENT. It denotes services administered by medical staff such as a technician and will be recorded on the UB-92 Claim Form with modifier –TC.

TPCP. Third Party Collection Program

TPOCS. Third Party Outpatient Collection System. Compiles outpatient visit information from Ambulatory Data System (ADM), and ancillary testing or services information from the Composite Health Care System (CHCS). Using rate tables for billing services from DoD Comptroller, the system generates bills for accounts receivable, refunds or other health care insurance purposes.

UBU. Unified Biostatistical Utility. The committee is responsible for capturing and standardizing biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses and algorithms across the MHS.

UCF. Universal Claim Form. A paper claim form used to bill pharmacy claims only.

UNBUNDLING. The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressing and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments.

UNIT OF SERVICE. The number of days or units that were supplied for a particular listed CPT/HCPCS code will be populated in Item 24G. If only one service was provided, the number "1" should appear.

VISIT. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.